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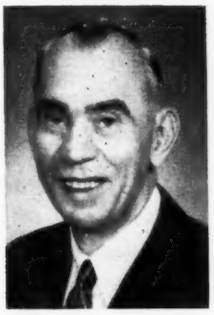
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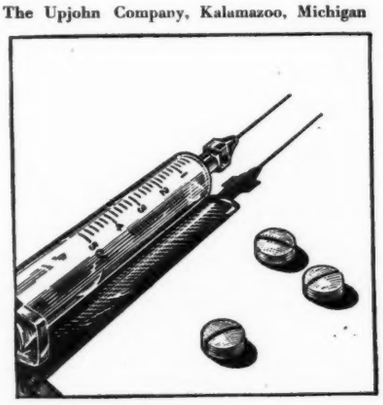
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SPECIAL COMMITTEE TO STUDY MODEL CONSTITUTION AND BY-LAWS

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F. M. Doyle, M.D.....1001 American Natl. Bank Bldg., Kalamazoo
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P. E. Sutton, M.D.....629 Wash. Square Bldg., Royal Oak

STUDY COMMITTEE ON FEES FOR SURGICAL ASSISTANTS

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Raphael Altman, M.D.....1052 Maccabees Bldg., Detroit
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E. H. Fenton, M.D.....15125 Grand River Ave., Detroit
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You and Your Business

HELP MAKE A 3,000 ATTENDANCE RECORD IN GRAND RAPIDS
MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
September 23-24-25, 1953

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of February 18, 1953

Sixty-seven (67) items were presented to the Executive Committee of The Council on February 18. Chief in importance were:

- **Public charges made by Paul R. Hawley, M.D.,** in the national press, and a resolution introduced into the Michigan Legislature by Senator Charles J. Blondy (Dem., Detroit) demanding an examination of Dr. Hawley's charges as they apply to Michigan, were discussed. A press release was drafted by the Executive Committee of The Council and released through The Council Chairman to the press of Michigan (see page 238, March JMSMS).
- **Committee Reports.** The following were given consideration: (a) Advisory Committee to Michigan State Medical Assistants Society, meeting of January 31; (b) Study Committee on Basic Science Law, January 31; (c) Public Relations Committee, January 31 (and Subcommittee on Cinema, meeting of same date); (d) Cancer Control Committee, February 5; (e) Study Committee on Fees for Surgical Assistants, February 11; (f) Child Welfare Committee, February 11; (g) Advisory Committee to Selective Service System, January 14.
- **Report on the present dearth of applications** for medical school was discussed and further investigation ordered.



Council Chairman William Bromme, M.D., as "fun-processed" by his friend, C. L. Oden, M.D., of Muskegon.

- **Financial reports** were presented, studied and approved. Bills payable were presented and payment was authorized.
- **Committee Appointments:** H. M. Bishop, M.D., Saginaw, and J. Duane Miller, M.D., Grand Rapids, were added to Emergency Medical Service Committee; R. W. Teed, M.D., Ann Arbor, to Scientific Radio Committee; O. K. Engelke, M.D., Ann Arbor, to Legislative Committee.
- **Editor Wilfrid Haughey, M.D.,** recommended that brief "profiles" of the oldest practitioners (still in medical practice) in each county be published in JMSMS; also profiles of the Woman's Auxiliary President and the Michigan State Medical Assistants Society President. These recommendations were approved.
- **H. B. Zemmer, M.D.,** was designated as official MSMS representative to attend special meeting of Michigan Health Officers Association, Detroit, March 12; R. H. Baker, M.D., to attend Operating Room Nurse Conference, Detroit, March 12-13.
- **Blue Cross coverage terminates** when the doctor of medicine discharges the patient, according to information received from W. S. McNary, Executive Vice President, Michigan Hospital Service.
- **President R. J. Hubbell, M.D.** was authorized to attend the Ontario Medical Association meeting, Toronto, May 13-14, 1953, as official MSMS representative.
- **The name of Miss Emilie Sargent, R.N.,** Detroit, was approved for submission to the Governor as a nominee for the Michigan Crippled Children Commission.
- **Legal Counsel J. Joseph Herbert** presented written opinion on inquiry of a Detroit member re delegating to nurses the giving of intravenous infusions in hospitals.
- **Monthly report of Rheumatic Fever Coordinator** Leon DeVel, M.D. was presented and approved.
- **The purchase** of a flexible self-contained exhibit manufactured by Ivel Construction Corporation, was authorized.
- **A vote of thanks** was placed on the minutes to *Inside Michigan* magazine for its November 1952 article which featured the 1952 MSMS Annual Session.
- **The monthly report of Public Relations Coun-**

(Continued from Page 354)

E. R. SQUIBB & SONS 745 FIFTH AVENUE, NEW YORK 22, NEW YORK

Dear Doctor:

℞

Tolserol Tabs. 0.5 gram

Disp. #100

Sig: One tablet 3 to 5 times a day. Take after meals or with 1/3 glass of milk.

Usually Inadequate

This prescription is typical of many written for Tolserol Tablets*, as seen in a recent prescription survey.

Although some patients will respond to such low dosage, much better results can be obtained by following the recommended dosage: 1 to 3 grams, 3 to 5 times per day.

In accordance with this recommendation, the first dosage schedule for a patient could be:

℞

Tolserol Tabs. 0.5 gram

Disp. #100

Sig: Two tablets 3 to 5 times a day. Take after meals or with 1/3 glass of milk.

Better

Complete information on the use of Tolserol in muscle spasm of rheumatic disorders, neurologic disorders, and acute alcoholism is available from your Squibb Professional Service Representative.

Sincerely yours,

L. H. Ashe

L. H. Ashe, Manager
Professional Service Dept.

'TOLSEROL' IS A REGISTERED TRADEMARK

*Squibb 'Mephenesin'

HIGHLIGHTS OF THE COUNCIL

(Continued from Page 352)

sel H. W. Brenneman was presented and approved.

- **Discussion of matters of mutual interest** with State Health Commissioner, A. E. Heustis, M.D., included: (a) request to MSMS to review the budget of the Michigan Department of Health, which request was referred to the MSMS Finance Comm.; (b) a "Little Cabinet" has been set up by the Governor with Dr. Heustis representing the health agencies.
- **Beaumont Memorial.**—Report on the proposed contract for the building of the Beaumont Museum on Mackinac Island was presented by Past President Otto O. Beck, M.D., Birmingham.

AMA TAKES STAND ON DOCTOR-DRAFT LAW

The AMA Council on National Emergency Medical Service, meeting in Chicago a few weeks ago, adopted a position on certain aspects of the Doctor-Draft law in case it becomes necessary to endorse an extension of the law later on. The following recommendations were approved by the Board of Trustees, February 7:

1. Any proposed legislation should specifically extend the primary obligation of physicians now classified in Priorities I and II, who are not called into service before July 1, 1953, the current expiration date of the "Doctor Draft Law."

2. An amendment should be suggested to the basic Selective Service Act which would obligate physicians covered by the basic Act for military service without permitting deferments because of dependency or marital status.

3. The Association should advocate the adoption of legislation which would provide for the recognition of military service since September 1, 1939, with countries which were allies of the United States during World War II for purposes of the "Doctor Draft Law."

4. The present maximum age incorporated in the "Doctor Draft Law," i.e., registration, age 50; obligation to serve, age 51, should be preserved.

5. The present law should be amended to require registration of physicians, under age 50, who do not have reserve commissions in the medical corps of the Army, Navy or Air Force.

6. Physicians who have not served since September 16, 1940, should be called according to age—youngest men first, after physicians currently classified in Priorities I and II have been called up or deferred for reasons of essentiality or physical disability.

7. Physicians with military service since September 16, 1940, should be called according to past service—those with the least amount of service first, after physicians currently classified in Priorities I, II and III are called up or deferred for reasons of essentiality or physical disability.

8. No distinction should be made between service in World War II and service since June, 1950. For purposes of computing total service, military duty either as an enlisted man or officer, with the exception of time spent in a Navy V-12 or an Army Specialized Training Program should be included.

9. The present concept of deferring physicians regardless of their priority classification if they are essential to the national health, safety or interest should be continued.

10. Legislative authority to establish national and state medical advisory committees to the Selective Service System should be continued.

11. Any extension of the "Doctor Draft Law" should be limited to one year.

12. In an effort to insure a more equitable utilization

(Continued on Page 356)

Michigan State Medical Society
1953 Membership Card 1953
This is to certify that

_____ M.D.

is a member in good standing of the Michigan State Medical Society for 1953, and a member of a component County Medical Society. He is a graduate of an approved medical college and licensed by the State to practice medicine and surgery in all their branches.

Bring Card to Michigan Clinical Institute, March 11-12-13, 1953, and Annual Session, September 23-24-25, 1953.

J. Pernell Foster
Secretary

Rx — *to a new year of membership in the Michigan State Medical Society*

Clinical Course — *Michigan Clinical Institute (March 1953)*
MSMS Annual Session (September 1953)
Monthly JOURNAL MSMS
Postgraduate continuation courses
Projects of State Committees
Service of the MSMS Executive Office

Prognosis — *Professional protections and economic rewards*
Friendship and social affairs
Prestige of a great American professional organization.

R. J. Hubbell
President

Doctor: Your 1953 membership card welcomes you to a new year with the Michigan State Medical Society. The Michigan Clinical Institute, the September 23-24-25, 1953 Annual Session, THE JOURNAL each month, and many other services, such as protective and investigative committees, continuation courses, friendships and social affairs—all are yours as an MSMS member. These membership cards are being mailed as rapidly as the reports of membership dues are received from the County Medical Society Secretary. R. J. Hubbell, M.D., welcomes and urges every practitioner of medicine in Michigan to become active in a great American professional organization—the Michigan State Medical Society.



Breathing comfort as well as proper drainage and aeration of the sinuses during upper respiratory infections is assured by the swift and prolonged decongestive action of

NEO-SYNEPHRINE®

HYDROCHLORIDE

By shrinking the swollen mucosa, Neo-Synephrine permits drainage of purulent matter, restoring free breathing and relieving the headache caused by clogged passages.

RAPID AND PROLONGED ACTION Clearing of nasal obstruction follows within seconds after application of Neo-Synephrine and is unusually prolonged, so that comparatively few daily applications are necessary throughout the course of a cold.

WELL TOLERATED Neo-Synephrine is notable for its relative freedom from sting, virtual absence of compensatory congestion and also has been found relatively free from systemic side effects such as nervous excitation, cardiac reaction or insomnia even when tested on hypertensive, cardiac and hyperthyroid patients.[1]

NO APPRECIABLE INTERFERENCE WITH CILIARY ACTIVITY Neo-Synephrine not only restores nasal patency, but is compatible with ciliary action.

NO DROWSINESS Neo-Synephrine may be used by the ambulatory patient without danger of producing drowsiness or related sedative action. Applied topically, Neo-Synephrine confines its action to the upper respiratory passages.

SUPPLIED:

0.25% solution (plain), 1 oz., 4 oz. and 16 oz. bottles.

0.25% solution (aromatic), 1 oz. and 16 oz. bottles.

0.5% solution, 1 oz. bottles.

1% solution, 1 oz., 4 oz. and 16 oz. bottles.

0.5% water soluble jelly, ⅝ oz. tubes.

●

Neo-Synephrine, trademark reg. U.S. & Canada, brand of phenylephrine

●

1. Van Alyea, O. E., and Donnelly, Allen: Arch. Otolaryng., 49:234, Feb., 1949.

WINTHROP-STEARNS INC. • New York 18, N. Y. • Windsor, Ont.

AMA TAKES STAND ON DOCTOR-DRAFT LAW

(Continued on Page 354)

of medical manpower by the Armed Services, the Association should recommend the establishment of a new position as Assistant Secretary of Defense for Health Affairs. It appears that the proper way to provide for this would be by an amendment to the National Security Act of 1947, as amended. In this connection, it is believed that a continuing concerted effort should be made to effect a lowering of the present ratio of 3.7 physicians per 1,000 troops.

It also was agreed that in the presentation of testimony to the Congress attention should be called to many inequitable situations currently being created by recalling physicians with prior service to military duty for the same period of time (24 months) as physicians who never have served. It was strongly recommended that a lesser period of service be established for those physicians who had at least 12 months of prior military duty since February 16, 1940.

With respect to the recommendation of the House of Delegates that consideration be given to the establishment of an equitable point system for the call-up of physicians, the Board of Trustees recommended that the matter be investigated further before arriving at a final decision.

HAVE YOU PAID YOUR DUES?

The American Medical Association Annual Session will be held in New York City from June 1 to June 5, 1953. The headquarters, scientific and technical exhibits, and meetings will be at the Grand Central Palace, 44th and Lexington Avenues.

To avoid the usual congestion at the registration windows and to save yourself trouble and delay, the American Medical Association is issuing advance-registration cards which will make it possible to quickly register instead of waiting in line to have your record checked with the membership roster.

To register it is necessary for you to have a pocket card showing your membership dues in the American Medical Association paid for 1953. If you have not already sent in your check to cover 1953 dues, we suggest that you do so at once, so as to give us an opportunity to forward the payment to the AMA in time to have the AMA issue a pocket card and also an advance-registration card to you.

Debilitating conditions, such as carcinoma, can and often do cause latent tuberculosis to become active.

* * *

The coexistence of pulmonary tuberculosis with malignant disease becomes commoner as the average age of the group in whom tuberculosis is found increases.

* * *

Given a patient with intermenstrual or post-menopausal bleeding of traumatic or spontaneous origin or persistent unexplainable discharge, always do a biopsy and/or a dilatation and curettage before definitive therapy is instituted.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1953

May 7 Ingham County Medical Society's Clinic Day — Lansing

May 13 Wayne University Medical Alumni Clinic Day and Reunion — Hotel Fort Shelby, Detroit

May 21 The American College of Surgeons Annual Symposium on Trauma and Nutrition — Ann Arbor

June 1-5 AMA Annual Session — New York

June 2 Annual Clinic Day, Bon Secours Hospital — Detroit

June 19-20 Upper Peninsula Medical Society Annual Meeting — Escanaba

July 30-31 Annual Coller-Penberthy Medical Surgical Conference — Traverse City

August Third Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Michigan Society of North Central Counties — Grayling

Sept. 22 Michigan Chapter, American College of Surgeons — Grand Rapids

Sept. 23-25 MSMS ANNUAL SESSION — Grand Rapids

Oct. 7 Clara Elizabeth Fund for Maternal Health and Genesee County Medical Society — Flint

Oct. 21 Michigan Cancer Conference — East Lansing

Autumn MSMS Postgraduate Extramural Courses — Statewide

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

Especially effective against gram-positive organisms resistant to other antibiotics.

Low toxicity; reported side effects infrequent.

Special "high-blood-level" coating.
ERYTHROCIN, *0.1-Gm. (100-mg.) Tablets, bottle of 25.*

ERYTHROCIN

TRADE MARK

(Erythromycin, Abbott)

INDICATIONS Pharyngitis, tonsillitis, scarlet fever, erysipelas, pneumococcic pneumonia, osteomyelitis, pyoderma. *Also other infections caused by organisms* susceptible to its action, including staphylococci, streptococci and pneumococci.

DOSAGE Total daily dose of 0.8 to 2 Gm., depending on severity of the infection. A total daily dose of 0.6 Gm. is often adequate in the treatment of pneumococcic pneumonia. *For the average adult* the initial dose is 0.2 Gm. to be followed by doses of 0.1 or 0.2 Gm. followed by doses in the same range every four to six hours. *For severely ill patients* doses up to 0.5 Gm. may be repeated at six-hour intervals if necessary. Satisfactory clinical response should appear in 24 to 48 hours if the causative organism is susceptible to ERYTHROCIN. Continue for 48 hours after temperature returns to normal.

Abbott

1. McGuire et al. (1952), J. Antibiotics & Chemo., 2:281, June.
2. Heilman et al. (1952), Proc. Staff Meet. Mayo Clin., 27:385, July 16.
3. Haight and Finland (1952), New Eng. J. Med., 247:227, Aug. 14.

PR REPORT

Current Public Relations Activities of MSMS



Combining an attractive display and the use of motion pictures, the new Michigan State Medical Society exhibit was unveiled at the Michigan Clinical Institute in Detroit in March. The exhibit is available to County Medical Societies for fairs and local exhibitions.

MSMS Exhibit

An eye-catching exhibit stops the crowd while motion pictures tell your story.

That, in a nutshell, is the new Michigan State Medical Society exhibit which is available to County Medical Societies for use at county fairs and local exhibitions.

The MSMS exhibit fits into a space 10 feet wide and 3 to 5 feet deep. If your County Medical Society is offered a wider space, the balance of the width may be taken up with draperies.

An important element of any exhibit is the element of movement. This is present in the MSMS exhibit through the use of motion pictures. As noted in the photograph, the center portion of the exhibit contains a shadowbox. This shadowbox is a recessed motion picture screen. Behind the exhibit there is room for a motion picture projector. The projector is equipped with a special lens which throws the picture onto a mirror directly behind the shadowbox screen. The mirror in turn reflects the image on to the screen which is viewed by the exhibit audience.

Any 16 mm films may be used, but the three MSMS films, "To Save Your Life," "Lucky Junior" and "To Your Health" are recommended as they best tell the story of the medical profession in three areas of thought.

The motion picture sound apparatus is placed in the space below the shadowbox.

A second important element of the MSMS exhibit is its adaptability. Both the left and right wings of the exhibit are made of a special type of material containing horizontal and vertical holes. Pictures, shelves and models can be attached and arranged on these two panels to set the theme of the exhibit.

The public Relations Department of MSMS is developing other themes which might be utilized in the exhibit.

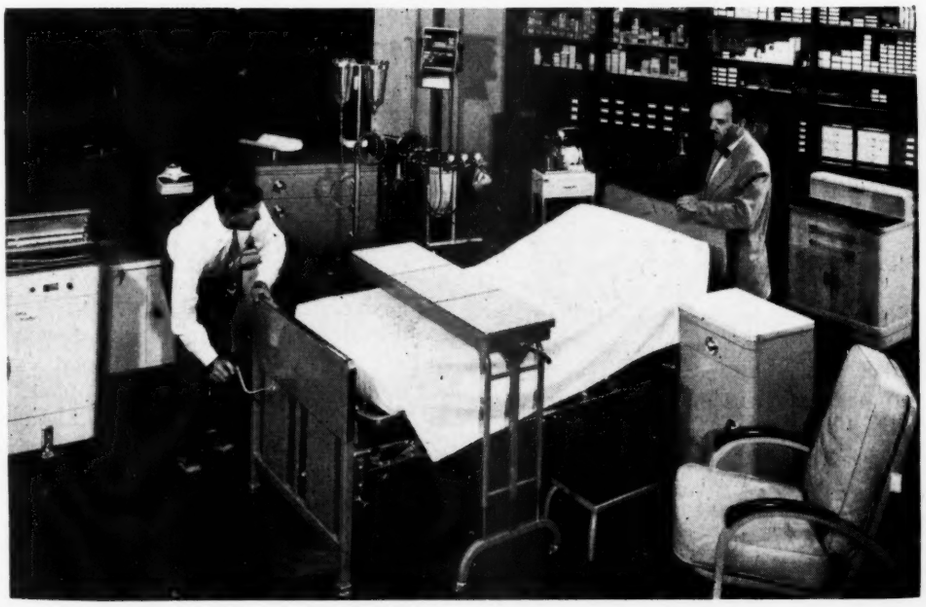
For further details on how to schedule the exhibit for your county fair or local exhibition, write the MSMS Public Relations Department in Lansing. Other information supplied by the Executive Office will include instructions on setting up the exhibit and recommended films and pamphlets to be used in conjunction with the exhibition.

Radio Package

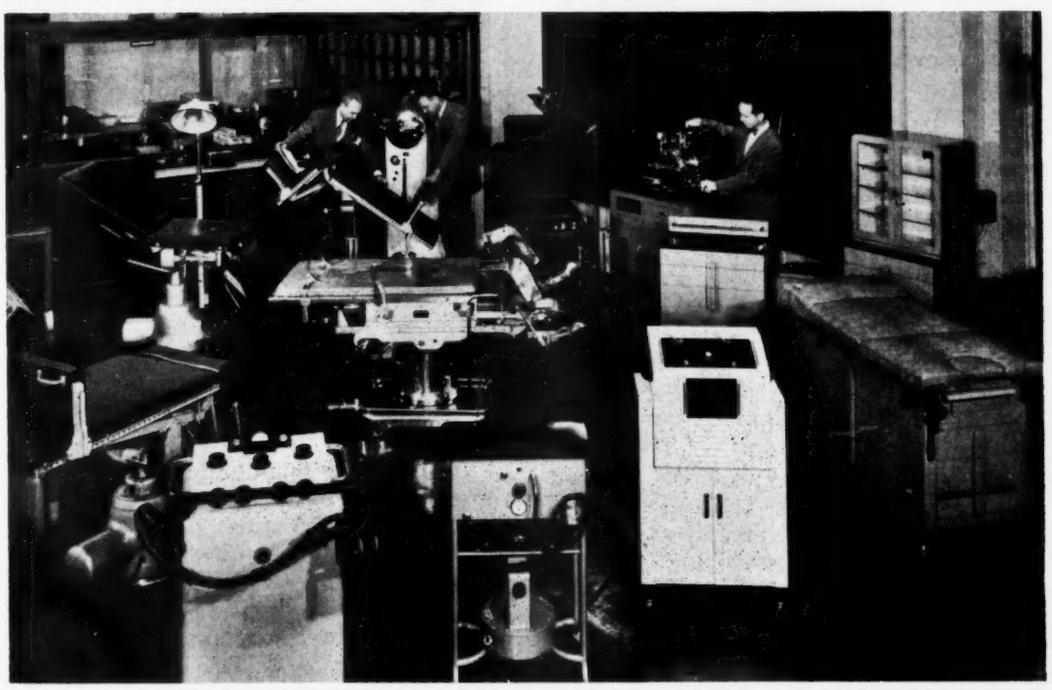
The Menominee County Medical Society introduced a new package radio series offered by MSMS. The 15-minute program was broadcast on Radio Station WMAW on March 9.

The package combines "Tell Me. Doctor" transcriptions plus discussion of a particular topic by a local doctor of medicine. "Tell Me Doctor" transcriptions are now available through the MSMS Executive Office in Lansing. A suggested 15-minute radio format is also available for use in presenting the series on a local level.

VISIT RANDOLPH



EVERYTHING YOU NEED ON DISPLAY



"For Finer Equipment"

Randolph Surgical

SUPPLY COMPANY

PHYSICIANS AND HOSPITAL SUPPLIES

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Michigan Foundation for Medical and Health Education, Inc.

Annual Reports

PRESIDENT'S ANNUAL REPORT

The accomplishments of the Foundation during the past year have necessarily been confined to the limits of our financial capacity and they have been held within these limits this year, as well as in the past years. To enumerate, they include co-sponsorships, student loans, student aid, responses to the various inquiries addressed to us and to the financial sponsorship and advisory service to the Michigan Rural Health Conference. The Rural Conference and the student loans are our two large expenditures.

The financial report will show that we have advanced to one prospective rural doctor $1,300 on his $1,500 loan and to another $200 on his $2,000 anticipated need. This makes a total of $1,500 advanced by the Foundation at the present time on the only two who have qualified, or to be plain and exact, on the only two applicants who have cared to qualify.

The Sixth Rural Health Conference was extended this year over the calendar year of 1952 to be held January 16 and 17 for the convenience of many of the participating groups and individuals. These January dates avoided many conflicts of Fall and early Winter experienced in the first four conferences. The exact cost of this last conference has not yet been determined but it is well within the appropriated limit. Press and radio were again most generous in publicizing this conference. The many co-sponsors found new ways this year to interest more people in this conference. Those concerned in the planning and management of this conference have been greatly gratified by the praise so generally expressed, ranging from a "good conference" to the "best yet."

In previous conferences the subjects selected have been general pertaining to hygiene, economics, insurance, protective measures, medical care, et cetera. This year it was found that the time had arrived when the discussion of particular diseases with the highest death rates was the popular desire. This was determined by a poll that reached more than 15,000 individuals and 4,100 community groups. The six discussion subjects thus selected were Polio, Cancer, Heart Disease, Rheumatic Fever, New Drugs and Their Uses, and Animal Diseases that Affect Man. The record attendance of 442 and the obvious interest shown in the several discussion groups as well as in the general assembly, was most gratifying to the planners of the conference.

The co-sponsors increased in number this year: 104 Michigan health organizations were thus listed on the programs, 318 paid attendants were credited to the annual banquet besides seventy-seven after-dinner guests. The speaker was the famous Dr. George F. Bond of Bat Cave, North Carolina, who has appeared in current periodicals and has received much recognition.

The Foundation's vice president, Burton R. Corbus, M.D., was the general presiding chairman of this conference and did a most admirable job. In a letter to the writer this week Doctor Corbus said, "I was very much impressed with the Rural Health Conference. The interest that was shown was quite heart warming, and I hope that we can, as a Foundation, continue our support." Mr. Eugene H. Wiard, executive secretary, Michigan Health Council, did a wonderful performance as secretary and developer of this conference. It does not seem that there could be a conference without his aid and participation, for he has become an intimate and personal part of the movement. The writer does not feel that he can compliment Mr. Wiard too highly on his outstanding performance.

This Foundation has supported the third, fourth, fifth and sixth Rural Health Conferences. The completed figures for expenditures for the third, fourth and fifth aggregate $5,933.71. This averages slightly less than $2,000 per conference as a cost provided by the Foundation.

On January 25, 1953, three Trustees of the Foundation, C. E. Umphrey, M.D., Mr. Gardner and Mr. Baxter, appeared in television on "The Court of Health." This show is promoted by the Michigan Health Council. The performance has attracted favorable comment concerning both acting and appeal to the video audience, to whom the cause of the Michigan Foundation for Medical and Health Education was further advanced.

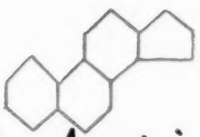
I am going to take the risk of boring you with figures in order to get before you the financial picture of this Foundation from its beginning. At the organization, September 19, 1945 we had the following: MSMS trust fund, bonds and cash, $23,519.61; Biddle estate estimated $28,953.46; pledges $19,000 with $5,000 paid in. It appeared then that we were starting business with $57,473.07 practically in hand, promises which suggested that we had a start of $71,473.07. Our pledges grew so that on January 15, 1946 we had $48,326.21 with paid in pledges of $33,451.31. This left unpaid pledges on that date of $14,675. This was our status within four months of our organization date.

There were some costs to organize and to do business and we were delayed in receiving the Biddle money because of stipulations in the will requiring that the distribution should not follow until the death of the last named beneficiary.

The yearly net worth of the Foundation from the beginning to the present is shown in the accompanying table:

(Continued on Page 364)

cortisone + SCHERING = Cortogen

the symbol SCHERING denotes leadership in steroid hormone  research and manufacture -- including Cortogen in the most useful clinical forms.

For systemic therapy, use Cortogen tablets SCHERING or injection  .

For eye  disorders use Cortogen ophthalmic suspension -- sterile  . The Schering seal SCHERING appears on each tablet and package -- your assurance of quality.

CORTOGEN®

Acetate (cortisone acetate, Schering) Tablets, 5 mg. and 25 mg.;
Injection, 25 mg. per cc., 10 cc. multiple-dose vials;
Ophthalmic Suspension—*Sterile*, 0.5% and 2.5%, 5 cc. dropper bottles.

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CORTOGEN

SCHERING

PRESIDENT'S ANNUAL REPORT

(Continued from Page 362)

Net Worth December 31, 1946,	$ 70,676.16
Net Worth December 31, 1947,	75,451.48
Net Worth December 24, 1948,	78,122.79
Net Worth December 23, 1949,	91,635.67
Net Worth December 22, 1950,	105,881.91
Net Worth December 24, 1951,	106,295.98
Net Worth December 26, 1952,	109,488.93

This table shows that our net worth has advanced a little each year. This growth, however, falls far short of the anticipations of the founders. We expected a rapid growth of an accumulation of funds which would at least reach seven figures. The doctor-support has been good but it has fallen far short to attract the probable lay support which would likely have followed a more substantial doctor contribution. There is no doubt that there are intended and probably there are a number of planned provisions for this Foundation to be realized in the future.

I wish to call to your attention again, an opportunity which has not been utilized except in a couple of instances. This Foundation is a vehicle to carry out a charity or a philanthropy without administrative cost to the donor. Aid by an individual to another individual is not deductible. The same aid, if done through the Foundation, and if it comes within the scope of the Foundation, may be handled to conform so that it is a deductible gift by the donor. Many doctors interested in this Foundation must have opportunities to advise friends and patients of this business opportunity.

EARL I. CARR, M.D.
Lansing

January 29, 1953

ANNUAL REPORT OF THE SECRETARY

The Secretary has executed the duties of his office according to the By-Laws and as provided in Robert's Rules of Order pursuant to the instructions of the members of the Board of Trustees, with the continued advice and guidance of President Carr and of Treasurer Gardner to whom the Secretary expresses gratitude and appreciation.

The Woman's Auxiliary to the Michigan State Medical Society was reminded on January 21, 1953 that interest in the amount of $20.00 on the $1,000 U. S. Government Bond (which the Woman's Auxiliary contributed to the Foundation in 1951) is due and payable.

Letters have been written to those who pledged amounts to the Foundation several years ago, seeking payment or a commitment. The following replied: H. R. Carstens, M.D., Chevy Chase, Md., acknowledged the pledge; L. G. Christian, M.D., Lansing stated that he had never signed a pledge; R. Earle Smith, M.D., Grand Rapids stated he was unable to pay. The balance did not reply.

The Biddle Fund of the Michigan Foundation for Medical and Health Education has been set up at the Michigan National Bank (Lansing Office) in accordance with instructions of the Foundation's Board of Trustees on January 24, 1952. The bonds in the Biddle Fund are:

Bonds	*Maturity*	*Present Book Value*
U. S. Bonds Series "F"	8/1/58	$ 797.00
U. S. Bonds Series "G" 2½%	8/1/58	$15,300.00
U. S. Bonds Series "G" 2½%	5/1/61	$10,000.00

The annual interest of these bonds approximates $640.00; the cumulative interest since the creation of the Biddle Fund (January 29, 1949) is $2,453.00.

These bonds are represented by safekeeping receipt A519, in the hands of the Secretary.

The Michigan Foundation for Medical and Health Education Lecture, to be given on the occasion of the 1953 Michigan Clinical Institute (with the speaker's expenses to be paid out of the Biddle Fund of the Foundation) will be presented by Michael M. Dacso, M.D., of New York City on March 13. 1953 in Detroit. Dr. Dacso's subject will be: "Management of the Chronic Disabling Diseases in the Aged."

A Biddle Lecture for a number of years has been presented in September on the occasion of the Michigan State Medical Society Annual Session with MSMS paying both the expenses and honorarium of the speaker. Does the Foundation wish to assume co-sponsorship of the Biddle Lecture in September and assume the expenses and honorarium of the Biddle Lecturer who appears at the MSMS Annual Session?

Fund-raising Possibilities.—Following instruction of the Board of Trustees at the January 24, 1952 meeting (Item 10 of the minutes), your Secretary dispatched letters to the following professional fund-raisers: American City Bureau, Chicago; Beaver Associates, Inc., Chicago; Ketchum, Inc., Pittsburgh; Pierce, Hedrich and Sherwood New York; Earl J. Smith and Associates, Detroit; Tamblyn and Brown Inc., New York; Ward Jenks and Associates, Chicago; Ward, Wells and Preshman, New York; Wells Organization, Cleveland.

Information received from these firms will be epitomized in a verbal report.

Respectfully submitted,
WM. J. BURNS,
Secretary

January 29, 1953

CONTROLS

When cotton was 3 cents a pound, wheat was 40 cents a bushel, and corn was 25 cents a bushel, the government adopted a price support program. With cotton selling for 33 cents, wheat for $2.35, and corn for $1.65, the depression born price support program is still in full force at a huge annual burden to the taxpayers.

At Your Service . . .

for Surgical Instruments,
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Heart Beats

SHORT CUTS TO A LONGER LIFE

"Housewives with heart disease have been called the largest segment of the working cardiac population. Since the woman with heart disease must in most cases go right on with her household chores, retraining is necessary to help her save time, motion and energy, thus lightening the load on her heart."



Mrs. Ruth C. Kettunen (seated at the ironing board above) of the Michigan State College Home Management Staff demonstrates one of the many "heart-saving" techniques which she is teaching in the Cardiac Housewife Classes being offered free to cardiac homemakers by the Michigan Heart Association. Sitting down to iron, lessens the strain placed on the heart by reducing the physical effort expended, Heart Association officials point out. Homemakers attending the classes learn practical ways of making their housekeeping simpler and easier by eliminating wasted energy and unnecessary steps. *No medical advice, diagnosis, treatment, or examination is given in the Cardiac Housewife Program.*

The Michigan Heart Association, with these thoughts in mind, embarked upon an extensive time and motion study of the daily household tasks of the homemaker. The entire project was undertaken with two important objectives: (1) to be of service to the Doctor of Medicine in prescribing relaxing work habits for his women cardiac patients and (2) to provide practical courses of instruction in work-simplification techniques without cost to the cardiac homemaker.

The initial study on the program, financed by the Michigan Heart Association through funds received in United campaigns, was carried out in Detroit by Mrs. Frances G. Sanderson, Chairman of the Home Economics Department at Wayne University. Working under medical guidance, and with cardiac homemakers, Mrs. Sanderson and her corps of assistants developed a course of instruction designed to fill the medical doctor's prescription of "take it easy" by showing the homemaker with a cardiac disorder how to save as much as 75 per cent of her walking, 75 per cent of her movements, and 60 per cent of her reaching while performing her daily household tasks.

Classes, based upon these studies, were then offered to cardiac homemakers in the Detroit area. Applications were accepted only upon the approval of the patient's attending Doctor of Medicine.

Early in 1951, the Michigan Heart Association provided funds to the School of Home Economics at Michigan State College to conduct a pilot study

(Continued on Page 368)

To the Doctors and Hospitals of Michigan . . .

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STATEMENT OF CONDITION

Report of Condition as of the Close of Business, December 31, 1952

MICHIGAN HOSPITAL SERVICE

ASSETS

Cash in Banks and Office	$ 4,239,807.51
United States Treasury and Defense Bonds	14,322,083.30
Accrued Interest	88,927.32
Subscription Fees—Receivable	184,293.48
Other Assets	294,859.47
Total Assets	$ 19,129,971.08

LIABILITIES AND RESERVES

Reserves for Payment for Services Rendered Subscribers (Including Unreported)	$ 9,004,172.36
Reserve for Unearned Subscription Fees	3,644,591.71
Reserve for Contingencies	6,149,243.79
Other Liabilities	331,963.22
Total Liabilities and Reserves	$ 19,129,971.08
Total Benefits Paid Since Inception	$206,347,035.71

MICHIGAN MEDICAL SERVICE

ASSETS

Cash in Banks and Office	$ 2,483,487.19
Real Estate—Home Office Property	638,375.53
United States Government and Government Guaranteed Bonds	6,984,810.64
Interest and Rents—Due and Accrued	65,954.77
Subscription Fees—Receivable	76,314.96
Funds Advanced for Veterans Administration	111,133.30
Other Assets	521,508.23
Total Assets	$ 10,881,584.62

LIABILITIES AND RESERVES

Reserve for Payments for Service Rendered Subscribers (Including Unreported)	$ 3,657,839.00
Reserve for Unearned Subscription Fees	1,707,957.72
Reserve for Contingencies	5,482,545.58
Other Liabilities	33,242.32
Total Liabilities and Reserves	$ 10,881,584.62
Total Benefits Paid Since Inception	$ 95,547,957.94

BLUE CROSS—BLUE SHIELD

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SHORT CUTS TO A LONGER LIFE

(Continued from Page 366)

along the lines used at Wayne University. The main purpose here, however, was to develop a program that would be usable in every community in Michigan.

Mrs. Ruth C. Kettunen of the College of Home Management staff was selected to direct this phase of the study. She also worked with women cardiac patients and under medical guidance. In a very few months Mrs. Kettunen, following a successful pattern developed at Wayne University, organized a course of instruction which could be used throughout the State utilizing the excellent services of the College Extension Service Agents in each county.

The classes are designed to benefit any economic level. The Michigan Heart Association does not endorse any products or equipment. Classroom instructors teach only principles, ideas and techniques of work-simplification. *No medical advice, treatment, diagnosis or examination is given to anyone in the classes.*

Some of the energy-saving ideas taught in the Cardiac Housewife Program include:

1. Sitting to do jobs whenever possible. Such things as washing dishes, preparing vegetables, mixing ingredients, ironing and dusting are excellent examples.
2. Arranging cupboards for maximum efficiency by placing seldom used utensils and dishes on the very high or very low shelves. Items used most often should be placed in the most convenient, or "arm-level" shelves.
3. Using two hands for dusting and putting away dishes.
4. Eliminating dish drying by scalding dishes and letting them drain dry.
5. An inexpensive, lightweight cart can also be a great step-saver. It may be used for transporting food from kitchen to table, setting and clearing the table, holding cleaning equipment and as a portable work table.

Since the initial series of classes in Wayne and Ingham Counties, the Cardiac Housewife Program has expanded to include Berrien, Kent, Genesee, Isabella, Grand Traverse, Benzie, Leelanau, Bay, Emmet and Charlevoix Counties. The year 1953 has witnessed another rapid expansion of the Cardiac Housewife Program so that more counties could be served. The "heart-saving" classes have been scheduled through September, 1953 in most of the above counties plus Saginaw Calhoun, Montcalm, Ionia, Allegan, Iosco, Arenac, Barry, Shiawassee, Charlevoix, Chippewa, Mackinac, Alger, Luce and Schoolcraft Counties.

Before the program is offered in any area of Michigan, the local County Medical Society is first contacted for its approval of the Program. Doctors of Medicine are urged to refer their patients to the free classes which are offered as a community service to doctor and patient by the Michigan Heart Association. If you are interested in further details on when the program will be scheduled in your area you are invited to contact the Michigan Heart Association, 4421 Woodward, Detroit 1, Michigan.

Michigan Registrations in Medicine

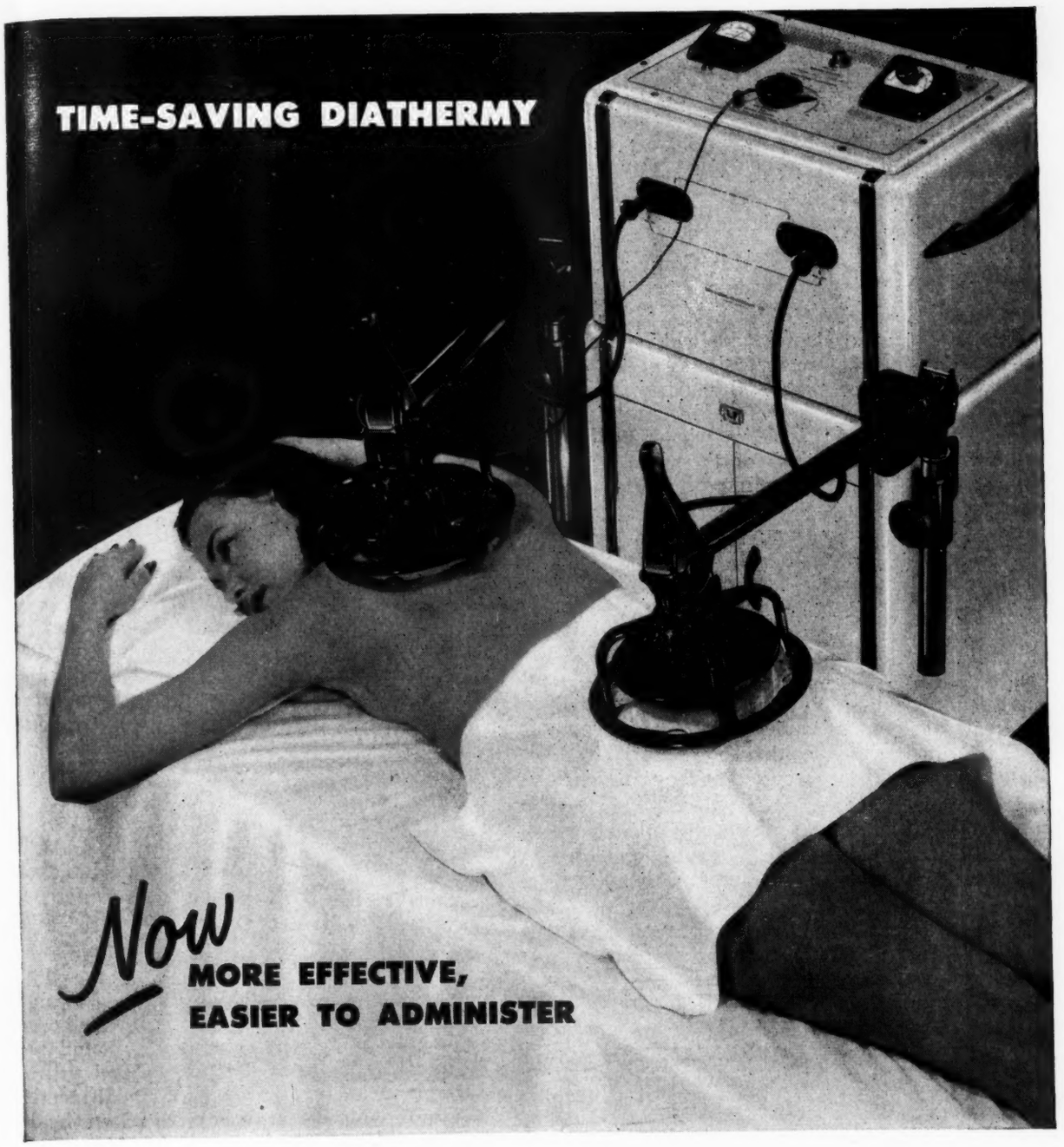
The following Doctors of Medicine have been granted licenses in Michigan. Numbers 20,204 to 20,220 inclusive:

By Endorsement.—Roger Alexander Smith *(North Carolina)*, William Edward Laupus *(National Board and Legalizing Examination)*, Joseph James Rowe *(New Jersey)*, Marvin Ross Bernard *(Indiana)*, Roman Fred Hauer *(Wisconsin)*, Robert Franklin Kandel *(National Board plus Legal Examination)*, Gerald Harry Zuckerman *(Colorado)*, Frank V. Sander, Jr. *(National Board plus Legal Examination)*, Kornelius Van Goor *(Maryland)*, Peter Mickael Agnone *(Pennsylvania)*, Graham Fraser Colquhoun *(Maine)*, Paul Rudolph Dumke *(Ohio)*, John David Trisler *(Ohio)*, David Charles Forrest *(Virginia)*.

By Examination.—Bernadette Barbara Stankey, Peter Elliott III, Sara Margaret Yager Alonso.

The following Michigan Doctors of Medicine were endorsed to the states named:

Irving D. Hellenga, Georgia; Linn A. Campbell, Illinois; Donald J. Ryan, Wisconsin; Alexander Grinstein, New York; Clifton Gustavus Myer, Tennessee; J. F. Ross, Ohio; Leo Eugene Robertson, Utah; M. J. Murray, California; Herschel Browns, Illinois; Sarah Catherine Linden, New York; Alan Reed Brown, North Carolina; Ira C. Walstrom, Washington; Irvine McQuarrie, California; Durwin Hall Brownell, Utah; Rex Ernest Buxton, Maryland; Fred Clinton Dalton, New York; Offlet Jackson Shore, Wyoming; Joseph E. Rosenfeld, Arizona; Herman Klein, Illinois; Robert Charles Peterson, New York; Donald Barrett Jury, California; Charles H. Flint, Arizona, Basic Science only; Harold P. Lynn, Nevada; Shirley Witham Martin, California; Nathan Eugene Martin, California; Leslie L. Lemak, Texas; Eldon Turley Perry, Pennsylvania; Arnald Michael Reeve, California; Fred Feigenson, California; Eugene J. P. Drouillard, Montana; Robert John McCandliss, Ohio.



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Sixth Annual Michigan Rural Health Conference Attracts Record Registration

Developed originally by MSMS in 1947, the Annual Michigan Rural Health Conference has grown to one of the outstanding meetings of its kind in the United States.

The Sixth Annual Conference, held this year at Kellogg Center on January 16 and 17, had a registration of more than 400 persons from all areas of the state. Well represented were delegates from County Medical Societies who contributed greatly in the deliberations of the panel discussions and who were largely responsible for what has been termed by many as the most successful Rural Health Conference program to date.

Health Subjects Selected By State-wide Survey Developed especially for this conference, a statewide survey of more than 4000 community groups polled a total in excess of 15,000 persons for subject material. Through this procedure, the people of Michigan were given the opportunity to name the six specific health subjects they would like to discuss and hear discussed at the conference.

Final tabulation of voting, based on a point system, identified the desired subjects as Polio, Heart Disease, Cancer, Rheumatic Fever, New Drugs and Their Uses and Animal Diseases that Affect Man.

Once the topics were selected, top resource persons were invited to discuss recent developments in each subject.

Doctors of Medicine Take Prominent Part Eight Michigan doctors served as top resource persons in the six panel discussion groups. Among those serving throughout the entire two-day meeting were: David G. Dickinson, M.D., Ann Arbor, Polio; Paul S. Barker, M.D., Ann Arbor, and Carleton Dean, M.D., Lansing, Heart; Leon DeVel, M.D., Grand Rapids, and Frank Van Schoick, M.D., Jackson, Rheumatic Fever; William L. Simpson, M.D., Detroit and Harry M. Nelson, M.D., Detroit, Cancer; William D. Robinson, M.D., Ann Arbor, New Drugs.

Burton R. Corbus, M.D., Grand Rapids, served as Assembly Chairman and E. I. Carr, M.D., Lansing, delivered the formal message from the sponsor at the opening assembly. A. C. Furstenberg, M.D. Ann Arbor, served as General Chairman for the conference planning and J. K. Altland, M.D. Lansing, served on the planning committee. J. S. DeTar, M.D., Milan, acted as chairman of the final assembly and presented the Andrew S. Brunk Award at the banquet.

The banquet address was presented by George F. Bond, M.D., of Bat Cave, N. C. He was formally introduced by R. J. Hubbell, M.D., President, MSMS, Kalamazoo.

Farm Theater Features Medical-Health Films Recently released medical and health films were featured at the Farm Theater, immediately following the Annual Banquet Friday night. The new AMA-RKO release "Your Doctor" featuring Dr. Bond, highlighted this session.

Health Exhibits Prove Popular Among the attractive health exhibits was the MSMS display of health advancement for 1953. Through a series of lighted panels controlled by the viewer, the exhibit presented an important message in two parts: (1) Your health is better today and (2) Less working time required to pay for it.

Many other attractive exhibits were displayed among which were the Michigan Heart Association's new movie shadow-box display and the Michigan Youth Commission's new exhibit, on public display for the first time at this conference.

Sponsorship List Further Expanded Following the First and Second Annual Michigan Rural Health Conferences, which were sponsored by MSMS, the Michigan Foundation for Medical & Health Education offered to provide the financial backing for the annual meeting with the provision that other Michigan health organizations be invited to act as co-sponsors. MSMS accepted the invitation and recommended that the Michigan Health Council be given the responsibility of planning and staging the conference.

The Foundation has continued its sponsorship since that time and the list of co-sponsors has grown from twenty-five to 104 this year.

Final Report Available Soon A complete final report of the conference is now being prepared. The report will include the complete text of Dr. Bond's address and full information on the panel deliberations.

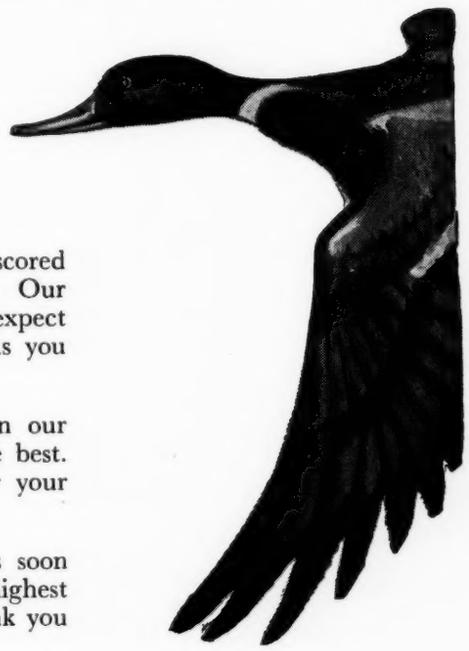
Copies of the report will be available free through Michigan Health Council, 706 N. Washington Avenue, Lansing, on request.





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Say you saw it in the Journal of the Michigan State Medical Society

County Secretaries Meet in Lansing, February 25



J. A. White, M.D.

Ideal weather greeted the Secretaries of Michigan's component county medical societies for their annual conference February 25. A spring-like day with sunshine and good driving attracted sixty-four registrants at Lansing.

J. A. White, M.D., Chairman of the County Secretaries during the past year, opened the meeting and introduced the various speakers: N. R. Moore, M.D., Bay City on "The Ballot Battle to Save Bay City General Hospital"; R. L. Novy, M.D.. Detroit and Louis H. Freye, Romeo, on "How to Report Cases to Michigan Medical Service"; H. E. Cope, M.D., Lansing on "Exchange of Scientific Programs Between County Medical Societies"; J. Joseph Herbert, LL.B., Manistique, on "Model Constitution and By-Laws for County Medical Societies"; E. A. Osius, M.D., Detroit, on "What About Basic Science Act?"; E. C. Swanson, M.D., Vassar, on "What About Medical Practice Act?"; and L. Fernald Foster. M.D. Bay City, on "Techniques—New and Old."

Honorable Wade Van Valkenburg of Kalamazoo, Speaker of the Michigan House of Representatives, presented an illuminating talk on "A Legislator's Problems." How laws are made, the membership of the "three" houses of the Legislature (including the "third house" composed of legislative representatives) was sketched by the Speaker who related many interesting and at times amusing anecdotes of the lawmakers' experience. This behind-the-scenes view of Michigan's lawmakers at work was the highlight of the day.

A special inspection tour of the MSMS "home" at 606 Townsend, Lansing, ended the days' session for the Secretaries of Michigan's component county medical societies.

L. Dell Henry, M.D., Ann Arbor long-time Secretary of the Washtenaw County Medical Society, was chosen Chairman of the County Secretaries Conference for the ensuing year.

Among the sixty-four registrants were included the six executive secretaries of county medical societies: Mrs. Lucy W. Bartlett, Muskegon; James Devereaux, Pontiac; Carl G. King, Saginaw; Miss Else Kolhede, Detroit; Mrs. Flora Mayer, Ann Arbor, and Mrs. Sara Warren, Flint.

Other registrants were:

County Secretaries—James E. Mahan, M.D., Allegan *(Allegan);* Harold Kessler, M.D., Alpena *(Alpena);* W. R. Birk, M.D., Hastings *(Barry);* L. Fernald Foster, Bay City *(Bay-Arenac-Iosco);* Robert W. Brown, M.D., Battle Creek *(Calhoun);* Edward H. Zwergel, M.D., Cassopolis *(Cass);* Thomas B. Mackie, M.D., Sault Ste. Marie *(Chippewa-Mackinac);* Donald G. Pike, M.D., Traverse City *(Grand Traverse-Leelanau-Benzie);* C. L. Hoogerland, M.D., Alma *(Gratiot-Isabella-Clare);* Arthur J. Stein, M.D., Hillsdale *(Hillsdale);* H. W. Porter, M.D., Jackson *(Jackson);* C. M. Schrier, M.D., Kalamazoo *(Kalamazoo);* Howard G. Benjamin, M.D., Grand Rapids *(Kent);* Ray M. Duffy, M.D., Pinckney *(Livingston);* Wm. A. Henkin, M.D., Mt. Clemens *(Macomb);* Samuel Osborn, M.D., Manistee *(Manistee);* A. S. Narotzky, M.D., Ishpeming *(Marquette-Alger);* J. A. White, M.D., Big Rapids *(Mecosta-Osceola-Lake);* W. S. Jones, Jr., M.D., Menominee *(Menominee);* Emily R. Hautau, M.D., Midland *(Midland);* Walter A. Meier, M.D., Monroe *(Monroe);* H. C. Tellman, M.D., Muskegon *(Muskegon);* A. R. Young, M.D., Pontiac *(Oakland);* G. A. Drake, M.D., Petoskey *(Northern Michigan);* C. H. Flint, M.D., Hart *(Oceana);* C. D. Selby, M.D., Port Huron *(St. Clair);* T. J. Dillon, M.D., Paw Paw *(Van Buren);* L. Dell Henry, M.D., Ann Arbor *(Washtenaw).*

County Presidents—W. G. Logan, M.D., Hastings *(Barry);* G. H. Rigterink, M.D., Kalamazoo *(Kalamazoo);* John A. Engels, M.D., Richmond *(Macomb);* O. R. MacKenzie, M.D., Walled Lake *(Oakland);* David P. Gage, M.D., Saginaw *(Saginaw);* E. T. Thieme, M.D., Ann Arbor *(Washtenaw).*

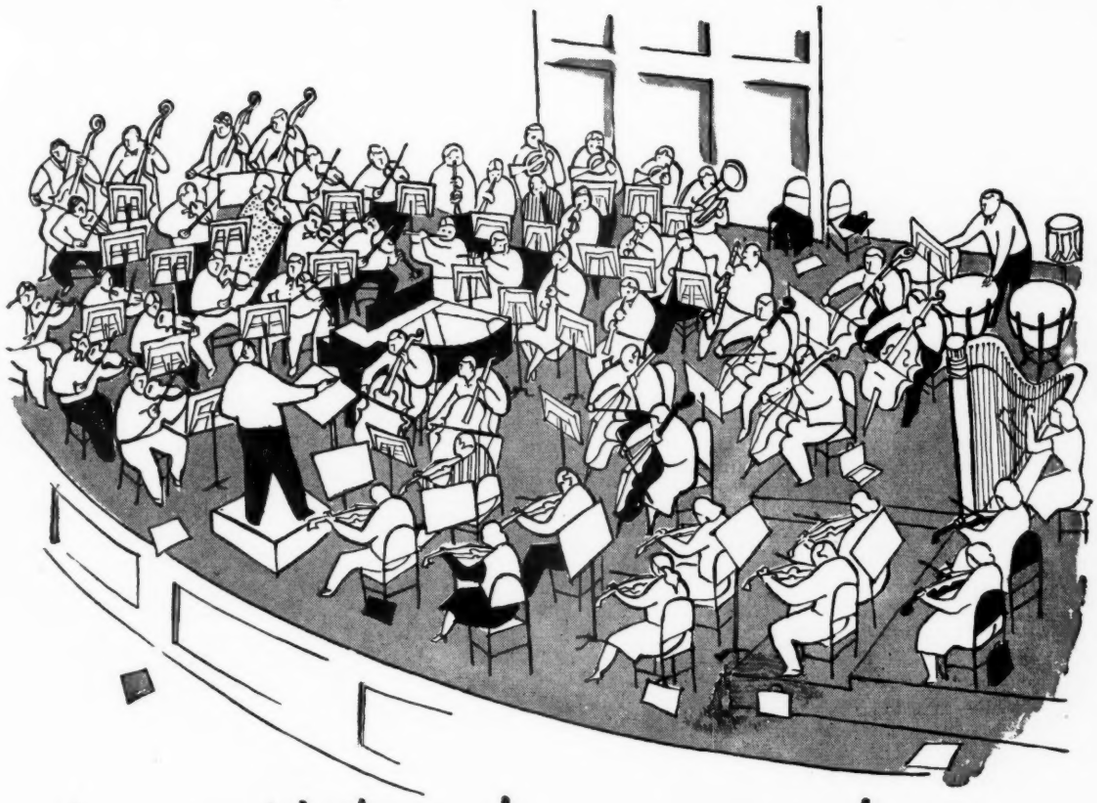
MSMS Council—Robert H. Baker, M.D., Pontiac; R. S. Breakey, M.D., Lansing; L. C. Harvie, M.D., Saginaw; R. J. Hubbell, M.D., Kalamazoo; W. S. Jones, M.D., Menominee; Ralph W. Shook, M.D., Kalamazoo.

Woman's Auxiliary Representatives—Mrs. Wm. Mackersie, Detroit; Mrs. W. S. Stinson, Bay City.

Michigan State Medical Assistants Society Representatives—Elizabeth E. Peck, Detroit; Lorine R. Nuechterlein, R.N., Saginaw; Margaret Schultz, Detroit.

Guests—H. F. Becker, M.D., Battle Creek; Frank V. Cargill, Chicago; George V. Conover, M.D., Flint; Carleton Dean, M.D., Lansing; J. Joseph Herbert, Manistique; Mrs. C. D. Selby, Port Huron; R. F. Staudacher, Chicago; Past President P. R. Urmston, Bay City.

Mrs. W. S. Stinson, Bay City, President-Elect of the Woman's Auxiliary to MSMS writes: "May I thank you for the courtesy and privilege of attending the MSMS County Secretaries Conference in Lansing on February 25. There is no doubt that the greater the knowledge and understanding of the activities of the Michigan State Medical Society which the Auxiliary and the membership have, the greater will be our scope of assistance to the Michigan State Medical Society and its membership."



they could stage their own symphony

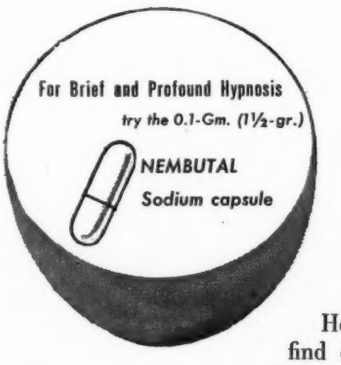
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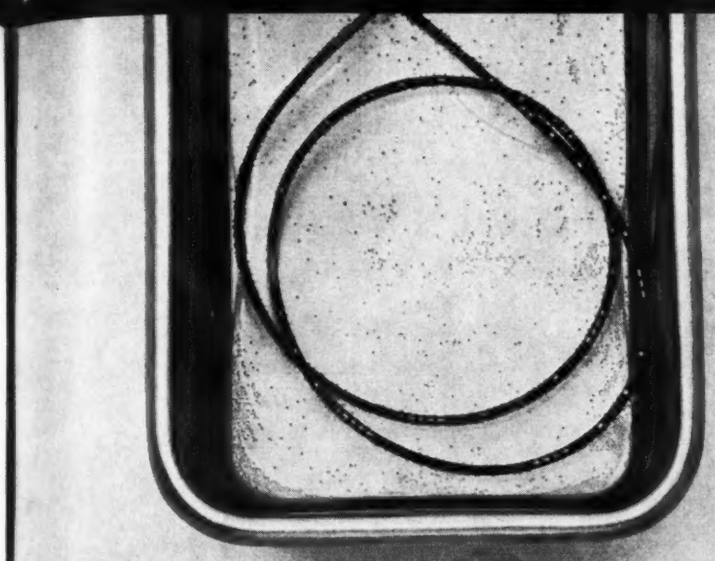
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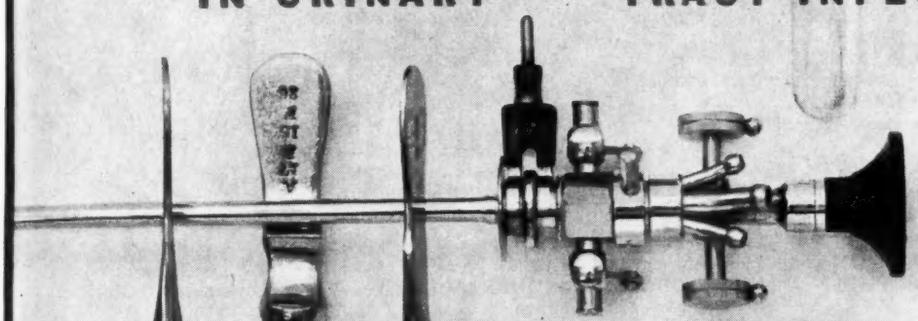
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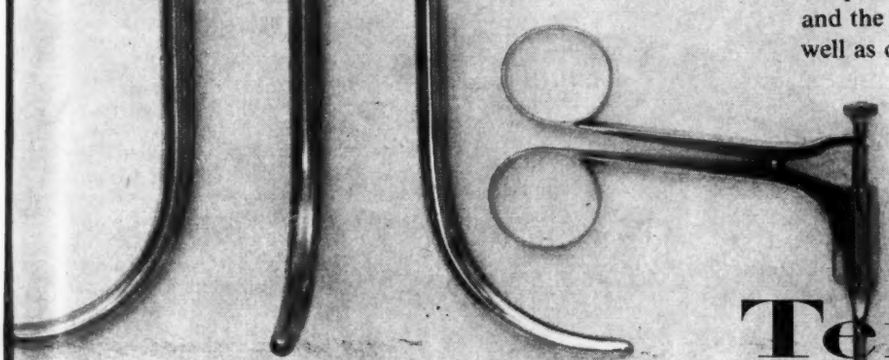
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rapid response "Patients with pyelitis were well and doing their usual duties within 24 hours . . ."[1] ". . . resistant cases showed remarkable response."[2]

high urine levels "Terramycin was selected . . . in view of high urinary excretion rate following small oral doses of the antibiotic."[1]

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1. Canad. M. A. J. 66:151 (Feb.) 1952.
2. J. Urol. 67:762 (May) 1952.
3. Ibid. 69:315 (Feb.) 1953.

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Brand of Oxytetracycline

Pfizer

Michigan Health Council TV Shows

June 1, 1952 through March 1, 1953

WJBK-TV, Detroit, 10:30 a.m.—Sundays

1952

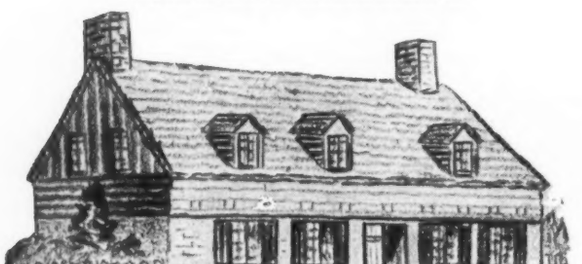
Date	Title	Names
June 1	"Areas of Co-operation in Health"	Otto O. Beck, M.D., President, MSMS J. K. Altland, M.D., Michigan Department of Health Glen Fausey, President, Michigan Hospital Association
June 8	"Opportunities in the Nursing Profession in Michigan"	Miss Lucy Germain, President, Michigan Nursing Center Association Mrs. Grace Wulff, Detroit Council on Community Nursing Jean Gibbs and Joan Engquist, Nurses
June 15	"Summer Health Hazards"	Arthur E. Schiller, M.D., Dermatologist, Detroit Lt. C. F. VanBlankensteyn, Commanding Officer, Safety and Traffic Bureau, Michigan State Police, East Lansing
June 22	No show due to coast-to-coast telethon with Crosby and Hope running through our regular time.	
June 29	"Activities of the Dearborn Health Council"	Mrs. Mary Finnson, Dearborn Health Department Harold Lynch, D.D.S., Dearborn Roscoe Simmons, Dearborn Public Schools Mrs. Muriel Binder, Dearborn Health Council Miss Atishun, Tuberculosis patient
July 6	"New Hope for Hearts"	Frederic Johnson, M.D., Wayne University College of Medicine Mrs. Hugh Wilson, Vice President, Michigan Heart Association
July 13	"Summer Sanitation"	John Hepler, Director of Engineering, Michigan Department of Health Morton S. Hilbert, Public Health Engineer, Wayne County Health Department, Eloise
July 20	"Farm Safety Week"	Wm. Buckinger, Farm Safety Engineer, Detroit Edison Co. Robert Richards, Past President Michigan Safety Conference
July 27	"Faith in Your Pharmacist"	J. N. Mandiberg, M.D., Detroit general practitioner David Karp, Vice President, Michigan Pharmaceutical Association Henry Maicki, Executive Committee, Michigan Pharmaceutical Association
Aug. 3	"Polio in Michigan"	Thomas Francis, Jr., M.D., School of Public Health, University of Michigan Mrs. Robert Langford, Chairman, Local Committee of National Foundation for Infantile Paralysis
Aug. 10	"How the Automobile Industry Safeguards the Health of Its Workers"	E. A. Irvin, M.D., Medical Director, Cadillac Motor Co., Division of General Motors Corporation Clifford H. Keene, M.D., Medical Director, Kaiser-Frazer Corporation Ralph G. Smith, Chief Chemist, Department of Industrial Hygiene, Detroit Department of Health W. A. Dawson, M.D., Assistant Physician, Rouge Plant, Ford Motor Company
Aug. 17	"Activities of the Garden City Health Council"	W. H. Kern, M.D., General Practitioner, Garden City Beatrice West, Member, Garden City Health Council and Public School Teacher
Aug. 24	"The Mentally Retarded Child"	Lee Trumble, President, Coldwater Parents Association Harold McKercher, President, Michigan Association of Parents and Friends of Mentally Retarded Children Raymond Mulchahay, Director, Coldwater State Home and Training School
Aug. 31	"Guard Your Heart" Due to Labor Day week-end, entire time was devoted to Heart Association film	

Sept. 7	"Better Schools Make Better Communities"	E. DALE KENNEDY, D.E., Assistant Executive Secretary, M.E.A. CHARLES E. BRAKE, D.E., Deputy Superintendent of Schools, Wayne County
Sept. 14	"Advances in Medicine"	L. FERNALD FOSTER, M.D., Secretary, MSMS ARCH WALLS, M.D., Chairman, Arrangements Committee, MSMS
Sept. 21	"Socio-Economic Aspects of Medicine"	G. W. SLAGLE, M.D., Councilor, MSMS R. W. SHOOK, M.D., Councilor, MSMS W. S. JONES, M.D., Chairman, Finance Committee
Sept. 28	"Women at Work—In Medicine"	MRS. WILLIAM MACKERSIE, President, Woman's Auxiliary, MSMS MRS. A. E. MILFORD, First Vice President and Public Relations Chairman, Woman's Auxiliary
Oct. 5	No Production—cancelled by station due to unavoidable commitments	
Oct. 12	"Work Being Done by the Michigan Public Health Association"	OSCAR STRYKER, M.D., Director, Macomb County Health Department MISS PATRICIA WALSH, R.N., President, Michigan Public Health Association LARUE MILLER, Secretary, Michigan Public Health Association
Oct. 19	"Contributions to Community Made by Wayne University College of Medicine"	WILLIAM L. SIMPSON, M.D., Scientific Director, Detroit Institute of Cancer Research GORDON H. SCOTT, Ph.D., Dean, College of Medicine, Wayne University ALBERT D. RUEDEMANN, M.D., President, Kresge Eye Institute; Professor of Ophthalmology, Wayne University
Oct. 26	"Organized Attack on Cerebral Palsy in Michigan"	CLARENCE H. EISMAN, M.D., Deputy Director, Crippled Children Commission EARL J. HUDSON, State Director, United Cerebral Palsy Association of Michigan DALE RENAULT, Executive Secretary, United Cerebral Palsy Association of Michigan
Nov. 2	"Diabetic Detection"	WALTER L. ANDERSON, M.D., Chairman, Diabetes Detection Committee, Wayne County Medical Society GEORGE C. THOSTESON, M.D., Council-member, American Diabetes Association
Nov. 9	"Activities of Michigan Farm Bureau"	MRS. HARRY WHITTAKER, Chairman, Michigan Farm Bureau Women; Member, Board of Directors and Board Member, Michigan Hospital Service MRS. CARL BUSKIRK, Member, Women's Committee, Van Buren Farm Bureau KEITH TANNER, Director, Field Services, Michigan Farm Bureau
Nov. 16	"What You Should Know About Cancer"	CLIFFORD H. KEENE, M.D., Co-chairman, Cancer Control Committee, MSMS HARRY M. NELSON, M.D., President, American Cancer Society ALBERT E. HEUSTIS, M.D., State Health Commissioner, Michigan Department of Health
Nov. 23	"The Nurse in Industry"	MRS. THELMA DURHAM, President, National Association of Industrial Nurses, Memphis, Tennessee MISS HELEN DECOURSEY, R.N., Kelsey-Hayes Main Plant, Detroit MISS MARION CASTERDALE, R.N., Upjohn Co., Kalamazoo MRS. BEULAH SATTLEY, R.N., Chrysler Corporation, Detroit
Nov. 30	"Center Line Community Health Council"	MRS. EVELYN ZEISS, President, Center Line School Health Council CLARENCE CROTHERS, Superintendent, Center Line Public Schools MRS. MARTHA SCHARF, Past President, Center Line School Health Council
Dec. 7	"Seal of Faith"	FRANK G. SCHEMANSKE, Judge, Wayne County Recorders Court; Member, Board of Directors, Tuberculosis and Health Society, Wayne County DAVID LITTLEJOHN, M.D., Director, Wayne County Health Department; Member, Board of Trustees, Michigan Tuberculosis Association NORBERT REINSTEIN, Director of Health Education, Tuberculosis and Health Society of Wayne County

Dec. 14	"Detroit's Holiday Safety Campaign"	ALGER F. MALO, Director, Department of Streets and Traffic LOUIS J. BERG, Inspector, Stationary Traffic and Traffic Safety Bureau DONALD SLUTZ, Managing Director, Traffic Safety Association of Detroit
Dec. 21	"Childhood's Greatest Enemy"	B. I. JOHNSTONE, M.D., Chairman, Rheumatic Fever Control Committee, Wayne County Medical Society MANES HECHT, M.D., Rheumatic Fever Research Investigator, Children's Hospital, Detroit; Member, Wayne County Medical Society—Rheumatic Fever Control Committee
Dec. 28	"Preface to a Life" (film)	
1953		
Jan. 4	"Michigan Rural Health Conference"	PAUL MILLER, Assistant Professor of Sociology and Anthropology, Michigan State College; co-chairman of discussion activities for Rural Health Conference E. H. WIARD, Secretary, Rural Health Conference; Executive Secretary, Michigan Health Council
Jan. 11	"Weight Reduction Through Diet"	DENA CEDERQUIST, Ph.D., Associate Professor, Department of Foods and Nutrition, School of Home Economics, Michigan State College MISS JENNY DAY, formerly Dietitian, University Hospital, Ann Arbor; presently Nutrition Specialist for Extension Services, Michigan State College
Jan. 18	"Responsibilities of Your Sanitary Engineer"	C. H. BRACY, Assistant Chief of Bureau of Marketing and Enforcement, State Department of Agriculture C. J. TURNEY, Director, Bureau of Sanitation for Lansing-Ingham County Health Department
Jan. 25	"Michigan Foundation for Medical and Health Education, Inc."	C. E. UMPHREY, M.D., Member, Board of Trustees, Michigan Foundation H. H. GARDNER, Treasurer, Michigan Foundation for Medical and Health Education C. STEWART BAXTER, Member, Board of Trustees, Michigan Foundation
Feb. 1	"To Save Your Life" (film)	
Feb. 8	"The Planned Parenthood Movement"	MRS. FRANCIS SCHILLING, Past President, Michigan League for Planned Parenthood Three representatives of foreign countries
Feb. 15	"Influenza and the Cold"	O. K. ENGELKE, M.D., Director, Washtenaw County Health Department F. P. RHOADES, M.D., General Practitioner, Detroit
Feb. 22	"Rehabilitation"	KATHRYN J. MCMORROW, M.D., Psychiatrist, Henry Ford Hospital
Mar. 1	"Goiter Control"	J. K. ALTLAND, M.D., Michigan Department of Health B. E. BRUSH, M.D., Iodized Salt Committee, MSMS

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The JOURNAL
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VOLUME 52 APRIL, 1953 NUMBER 4

Does the Law Seal the Doctor's Mouth?

By J. Joseph Herbert, LL.B.
Manistique, Michigan

FOUR HUNDRED years before Christ, during the glorious Periclean Age, the celebrated Greek physician, Hippocrates, enunciated in form of a remarkable Oath the professional ideals of his calling. This ancient avowal has come down through the centuries so consistent with contemporary ethical concepts that even today most every doctor at the time of his graduation from medical school takes the Oath as the code of honor of his profession. Its last covenant pledges that:

"Whatever, in connection with my professional practice or not in connection with it, I see or hear, in the life of man, which ought not to be spoken abroad, I will not divulge, as reckoning that all such should be kept secret."[1]

The secrecy so promised has had such general recognition by doctors and laymen alike that our social institutions have often found it difficult to avoid its ethical impact. Nevertheless, this precept of relatively high moral value has been forced to yield in considerable measure when it collided with other ethical concepts regarded by society as transcendent for the *summun bonum.* To what extent the private engagement arising from a code of honor should yield to the demands of legal and social justice in a democracy has been and is yet being debated by our courts, legislative bodies and the medical profession itself. And its application to the rights of man reflects generally the concern which society has in choosing a course which is most likely to advance the ethical and material welfare of the greatest number. In this instance as in others the law has followed social attitudes quite closely in principle, if not so closely in point of time.

The American Medical Association in recognition of social imperatives has relaxed the sweeping quality of the Oath in its published *Principles of Medical Ethics,* which contain the following pertinent provisions:

"The confidences concerning individual or domestic life entrusted by a patient to a physician and the defects of disposition or flaws of character observed in patients during medical attendance should be held as a trust and should never be revealed except when imperatively required by the laws of the state. There are occasions, however, when a physician must determine whether or not his duty to society requires him to take definite action to protect a healthy individual from becoming infected, because the physician has knowledge, obtained through the confidences entrusted to him as a physician, of a communicable disease to which the healthy individual is about to be exposed. In such a case, the physician should act as he would desire another to act toward one of his own family under like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

A physician should give timely notice of dangerous manifestations of the disease to the friends of the patient. He should neither exaggerate nor minimize the gravity of the patient's condition. He should assure himself that the patient or his friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family."[2]

It is to be noted from the quoted passages that the profession makes specific exceptions to the pledge of secrecy in cases of communicable diseases, and where the law makes no provisions for

Mr. Herbert is Legal Counsel for the Michigan State Medical Society.

1. *Perry* v *Hannagan,* 257 Mich. 120, 122.

2. Principles of Medical Ethics of the American Medical Association, Chapter II, Sections 1 and 2.

privileged communications or limits the application of the rule. Moreover, there is a positive mandate that the physician give timely notice to friends of the patient of "dangerous manifestations of the disease." Obviously, the profession in its ethical attitude to confidential communications has "rolled with the punch" of modern social demands.

Although this short discussion attempts to relate the attitude of the law to the physician's code of honor, it is not intended as a treatise on the procedural law of privileged communications or on the substantive law concerned with unauthorized disclosures by physicians out of court. Rather, its purpose is to point out the extent to which the original concept of full secrecy has been relaxed by the law of Michigan within three areas, viz., in proofs from the witness stand, in daily life, and in regulatory legislation.

Disclosures On The Witness Stand

Strictly speaking, the expression "privileged communication" relates to a rule essentially one of evidence, applicable to proofs from the witness stand, and not to disclosures made outside of judicial or quasi judicial tribunals. The so-called privilege allows a patient in court, on formal objection, to seal the mouth of his physician against testifying to certain matters which the witness learned in his professional capacity. This "privilege" depends solely on statute and has no counterpart at common law.[3]

Interestingly enough, the struggle between the doctor's code of honor and the demands of justice arose not from disclosures by physicians on the street, in club rooms, or medical journals, but rather when doctors were on the witness stand and the court was trying to learn the truth so as to administer justice.

In 1776, at the notable bigamy trial of the Duchess of Kingston before the House of Lords,[4] the matter was completely settled for the common law of England. Mr. Hawkins, a physician who had attended the duchess and her alleged husband, was asked on the stand: "Do you know from the parties of any marriage between them?" Ans: "I do not know how far anything that has come before me in a confidential trust in my profession should be disclosed, consistent with my professional honor." Whereupon the Lord Chief Justice Mansfield in measured words replied:

> "If all your lordships will acquiesce, Mr. Hawkins will understand that it is your judgment and opinion that a surgeon has no privilege, where it is a material question in a civil or criminal cause to know whether parties were married or whether a child was born, to say that this introduction to the parties was in the course of his profession and in that way he came to the knowledge of it*** If a surgeon was voluntarily to reveal these secrets, to be sure, he would be guilty of a breach of honor and of great indiscretion; but to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever."

To this day in England there is no privilege between physician and patient, and the physician is compelled by law to testify to confidential matters relating to his patient. This common law rule would probably still be the law in the United States but for the fact that in 1828 the State of New York adopted a novel statute, establishing a physician-patient "privilege." Thereafter, thirty-four American jurisdictions, including Michigan, adopted similar acts.[5] Although these statutes are not uniform in wording, and now contain material variations, in essence they provide that physicians and surgeons may not, without the consent of the patient, be examined as to any information acquired in attending the patient, which was necessary to prescribing or acting as a physician or surgeon. On the other hand, seventeen states, including all of those of New England, have adhered to the English common law and do not recognize the privilege.[6]

Perhaps the best argument in support of the privilege statute was advanced by the *Commissioners On Revision Of The Statutes Of New York* in 1836.

> "The ground on which communications to counsel are privileged, is the supposed necessity of a full knowledge of the facts, to advise correctly, and to prepare for the proper defence or prosecution of a suit. But surely the necessity of consulting a medical adviser, when life itself may be in jeopardy, is still stronger. And unless such consultations are privileged, men will be incidentally punished by being obliged to suffer the consequences of injuries without relief from the medical art,

3. *Campau* v *North*, 39 Mich. 606.
4. Duchess of Kingston's Trial, 20 HOW. ST. TR. 573.
5. Alaska, Arizona, Arkansas, California, Colorado, District of Columbia, Hawaii, Iowa, Idaho, Indiana, Kansas, Kentucky, Michigan, Missouri, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Ohio, Pennsylvania, Philippine Islands, Puerto Rico, South Dakota, Utah, Virgin Islands, Washington, West Virginia, Wyoming and Wisconsin.
6. Alabama, Connecticut, Delaware, Florida, Georgia, Illinois, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, Rhode Island, South Carolina, Tennesee, Texas, Vermont, and Virginia.

and without conviction of any offence. Besides, in such cases, during the struggle between legal duty on the one hand, and professional honor on the other, the latter, aided by a strong sense of the injustice and inhumanity of the rule, will, in most cases, furnish a temptation to the perversion or concealment of truth, too strong for human resistance."

It is to be noted, however, that the policy supporting the physician-patient privilege has been severely criticized by such scholarly writers as Wigmore,[7] Chafee[8] and Purrington.[9] Other lawyers have found serious fault with the rule.

In Wigmore's polemic against the privilege he lays down four postulates to test its validity:[10] (1) The communication must originate in a confidence; (2) the inviolability of that confidence must be vital to the attainment of the problems of the relation of physician and patient; (3) the relation must be one that should be fostered; (4) the expected injury to the relation, through disclosures, must be greater than the expected benefit to justice. He insists that if any one of these conditions is not satisfied it leaves the privilege without support. As to the first, he argues that only in rare instances are facts communicated to the physician confidential in a real sense, and that, excepting venereal disease and criminal abortions, most of one's ailments are immediately disclosed and discussed with the doctor as well as friends. As to the second, he points out that people are not deterred from seeking medical help because of the possibility of disclosure in court, and notes that in states where the privilege does not exist there is no reluctance on the part of the public to obtain medical aid. He concedes that the physician-patient relation should be fostered, hence the third postulate is satisfied. But, as to the fourth, he emphatically denies that its requirement is met. He urges that injury to justice by repression of facts of corporal injury and disease is a hundredfold greater than any injury that might be done by the disclosure. He declares that ninety-nine per cent of litigation in which the privilege is invoked consists of three classes of cases: actions for personal injuries, actions on policies of life insurance where the deceased's misrepresentations of his health are involved, and testamentary actions where the testator's mental capacity is disputed. He then asks the medical profession to reflect that the principal instances in which justice asks for disclosures are in personal injury and life and accident insurance, cases which the patient himself has voluntarily brought into court. Hence, the physician has no reason to reproach himself with the consequences that justice requires.

The most cogent judicial argument in opposition to the rule is to be found in *Maine* v. *Maryland Casualty Co.*, 172 Wis. 350, 178 N.W. 749, in which Justice Owen in a dissenting opinion said:

"The rule did not obtain at common law. It had its origin in the State of New York, and has been adopted by approximately one-half of the States of this country. It is said that it was enacted for the purpose of encouraging patients to disclose fully their ailments to their attending physicians without apprehension that their statements so made could be disclosed upon the witness stand to their humiliation and disgrace. As compared with the innumerable ailments to which the human flesh is heir, those which bring shame or disgrace to the sufferer are inconsiderable. Of those so afflicted who consult physicians but an inconsequential proportion are restrained from complete disclosure by apprehension of enforced publicity of shameful secrets. When we realize that but an insignificant segment of society requires protection of this nature, well may we wonder whether the shield designed for their benefit should be made so broad and ample as to constitute an insuperable barrier to the attainment of justice by the heirs and representatives of those who do not need such protection.

Ordinarily bodily affliction and disease are attended with neither shame nor disgrace. The character of one's ailment is not usually a secret. It is generally known to one's neighbors, friends, and acquaintances. In all the range of human affliction one can think of but one class of diseases that he would hide from his friends and neighbors, and that is venereal diseases. No other diseases, nor class of diseases, bring humiliation or shame or disgrace to the sufferer. He who has acquired venereal disease by clandestine liaison has scant claim upon legislative consideration for protection from the shame which he has deliberately invited. In the last analysis, therefore, this statute must be said to have been enacted to save from shame and disgrace those who by their own acts have forfeited their honor. If this could be done without at the same time working injustice to the innocent and the pure, the purpose might be generous and praiseworthy. But where the innocent are made to suffer to shield the wicked and the guilty from the publicity of their own misconduct, the cost of generous consideration becomes too great.

Taking society as a whole, this statute cheats rather than promotes justice. It suppresses rather than re-

7. Wigmore on Evidence (3d Ed.), Sections 2380-2391.
8. Zechariah Chafee, Jr.: Privileged Communications: Is Justice Served or Obstructed by Closing the Doctor's Mouth on the Witness Stand?, 52 Yale Law Journal 607.
9. Purrington: An Abused Privilege, 6 Col. L. Rev. 388.
10. Wigmore on Evidence (3d Ed.), Sections 2285 and 2380a.

veals truth. This case furnishes a splendid illustration of its consequences. Here a poor widow is turned out of court, unable to recover on a contract made by her deceased husband for her benefit because this statute closes the mouth of his attending physician. The same result must follow in any case for the recovery of damages for death caused by wrongful act, where the testimony of the attending physician is necessary to establish the causal relation between the injury and the death. The innocent should not be thus deprived of justice and made to pay the cost of the protection which this statute would afford to those who have forfeited all right to protection.

The centuries of experience during which the common law was developed did not give rise to this rule. * * * Well may this statute receive legislative reconsideration, and if it be still thought desirable to afford protection to those who have but scant claim upon the considertion of society, then let it be so framed that such protection can be extended without working hardship and injustice to the innocent and the pure."

Be arguments pro and con what they may, Michigan adopted the rule by statute in 1846,[11] although the provisos which now appear in the act to remove its serious strictures in personal injury actions (including workmen's compensation cases), malpractice suits and will contests were not added until 1909 and 1915.

The present form of the statute is as follows:

"No person duly authorized to practice medicine or surgery shall be allowed to disclose any information which he may have acquired in attending any patient in his professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon: Provided, however, that in case such patient shall bring an action against any defendant to recover for any personal injuries, or for any malpractice, if such plaintiff shall produce any physician as a witness in his own behalf, who has treated him for such injury, or for any disease or condition, with reference to which such malpractice is alleged, he shall be deemed to have waived the privilege hereinbefore provided for, as to any or all other physicians, who may have treated him for such injuries, disease or condition: Provided, further, that after the decease of such patient, in a contest upon the question of admitting the will of such patient to probate, the heirs at law of such patient, whether proponents or contestants of his will, shall be deemed to be personal representatives of such deceased patient for the purpose of waiving the privilege hereinbefore created."[12]

The privilege so set out is, of course, no broader than the plain provisions of the statute reasonably construed by the courts. Nevertheless, under Michigan law there are many important situations, even under the statute, where the seal is not applied to the doctor's lips.

First of all, it must be borne in mind that the privilege is one personal to the patient, and does not belong to the physician.[13] Accordingly, the physician cannot claim it if the patient abandons it. His abandonment may be express or implied. Our court has held, for example, that unless the privilege is asserted by or for the patient through formal objection before the doctor testifies, it ceases to be a privilege, and the doctor cannot insist on remaining silent.[14]

The patient has been deemed to have waived the privilege under other circumstances, as when she voluntarily took the stand and testified to matters within the privilege. The court thereupon permitted her physician to testify on subjects otherwise regarded as confidential.[15] And if a patient furnishes statements in a proof of death containing confidential matter which would be privileged under the statute, he waives his statutory privilege to that extent, and his physician may testify on the same subject.[16]

Personal injury and malpractice suits, including workmen's compensation cases, constitute possibly ninety per cent of all those in which the privilege would ordinarily be invoked. However, in such litigation the express language of the statute virtually forces plaintiffs to abandon the privilege, for, as a practical matter, such plaintiffs almost invariably find it necessary to support their claims by medical testimony, whereupon the defense is free to examine and cross-examine doctors as to matters otherwise within the privilege.

In will contests, wherein the mental and physical health of the testator is an issue, there is seldom any question of privilege, for under the statute if the heirs as proponents do not choose to waive it, then heirs as contestants of the will certainly may and do.

But even when the patient does not expressly or impliedly waive his privilege, many situations arise in which the law will not seal the lips of the medical witness. The phrasing of the statute expressly limits its application to information acquired by the doctor "in attending any patient

11. Sec. 86 R.S. '46 Ch. 102.
12. C.L. 1948 617.62; M.S.A. 27.911.
13. *Fraser* v *Jennison*, 42 Mich. 206; *Storrs* v *Scougale*, 48 Mich. 387; *Lincoln* v *City of Detroit*, 101 Mich. 245.
14. *Briesenmeister* v *Knights of Pythias*, 81 Mich. 525; *Lincoln* v *City of Detroit* supra.
15. *People* v *Kayne*, 268 Mich. 186.
16. *Briesenmeister* v *Knights of Pythias* supra.

in his professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon." So, if the doctor is engaged by another merely to examine the patient as to his physical or mental condition, and not to treat him, the information he gains in so doing is not privileged. And this is true when the patient is aware that he is being examined pursuant to court order or statutory right at the request of his adversary, the prosecuting attorney, or at the instance of the court itself. Thus, in a prosecution for rape, where the defendant voluntarily permitted examination of his shoulder, the physician was permitted to testify that he found bruises thereon.[17] In another rape case, the prisoner voluntarily submitted to an examination in jail by a physician, at the instance of the prosecutor. The examining physician was permitted to testify as to whether or not the "patient" was suffering from a venereal disease.[18]

Questions have frequently arisen whether the particular observations or communications brought confidentially to the doctor's attention on attending the patient are within the provisions of the statute. Although our court has been quite liberal in construing the factor of "necessity" of the observations or communication to aid in treatment, there are numerous instances when it has been held that the physician's testimony is not privileged by the statute.

In a damage suit growing out of an automobile collision, the plaintiff claimed that the defendant had been under the influence of liquor. He called the defendant's physician, who had attended him shortly after the accident for cuts and bruises. Over objection, the doctor was allowed to testify that he "noticed an odor of liquor on his breath." Our supreme court held the testimony properly admissible because this observation was not "necessary to enable the doctor acting as a surgeon to treat defendant's cuts and bruises." The court relied on the restrictive wording of the statute, and pointed out that the defendant did not seek treatment on account of his intoxication.[19]

In another damage suit wherein the plaintiff's intoxication was an issue, the supreme court held that his doctor should have been permitted to testify whether at the time of his examination the patient was under the influence of liquor. The decision was based on the court's conclusion that the information as to the plaintiff's condition was not necessary in order to enable the physician to prescribe for his ailment.[20]

In a bastardy case, the complaining witness disclosed who was the father of her child to her attending physician. On trial, the doctor's testimony in this regard was ruled out as a confidential communication within the prohibition of the statute. However, the supreme court concluded that the testimony was admissible because the information so gained was not necessary to enable the physician to prescribe for his patient.[21]

In a suit for annulment of marriage, the paternity of the defendant's child was in issue. The physician who had attended the defendant at the birth of her child testified that he had examined the hospital records, which showed the child's weight and length, and stated that in his opinion it was a full-term baby. The court held that this testimony did not disclose information which was "necessary to enable him to prescribe" for the defendant, and, therefore, was not barred by the statute.[22]

In an action to recover damages for personal injuries, including a rupture, the plaintiff's attending physician testified that she had admitted that her rupture was not caused by the defendant's acts, but was a pre-existing condition. The court held that it did not appear that this information was "necessary to enable the doctor to prescribe for her as a physician or to do any act for her as a surgeon," and was, therefore, admissible. The court said: "So far as practicable the courts ought to see to it that the statute is not used as a mere guard against exposure of the untruth of a party, and that a rule intended as a shield is not turned into a sword."[23]

Moreover, our Court has been loath to seal the doctor's mouth when it does not regard his information as having been given or obtained in confidence.

In a libel suit against a physician in which a newspaper charged the doctor with causing death by the careless use of a trocar in vaccination, the plaintiff called physicians to testify as to the condition of children whom they had attended following the vaccination. Objection was made to the testimony of such attending physicians because

17. *People* v *Wittersheim,* 252 Mich. 538.
18. *People* v *Glover,* 71 Mich. 303.
19. *Perry* v *Hannagan,* 71 Mich. 303.
20. *Lincoln* v *City of Detroit* supra.
21. *People* v *Cole,* 113 Mich. 83.
22. *Yager* v *Yager,* 313 Mich. 300.
23. *Campau* v *North,* 39 Mich. 606, 609.

the information obtained was in the course of medical treatment and because certain information had been gained from the parents of the children at the time of the visits. The supreme court, however, held the testimony of the physicians as to the children's condition to be admissible, saying, "the object of the statute is to prevent the abuse of the confidential relation existing between the physician and his patient and is for the protection of the latter. Where the relation is such that no confidence is reposed there is none to be abused."[24]

And in the Glover prosecution cited above, where the physician examined the prisoner in jail, the court in permitting the doctor's testimony said, "the privilege does not extend to cases where no confidential relations exist."

In another case, the letters of a wife to her husband containing confidential communications were held admissible as evidence, tending to show that she destroyed her insured property by fire, when the letters came into the possession of third persons, without collusion, by finding. In commenting on the subject of communications between husband wife, the court said: "The privilege is in derogation of the general rule that all persons may be compelled to testify concerning facts inquired about in courts of justice. It should be made effective, but ought not to be extended by the courts to cases where there has been no injury to the relation of the parties by the betrayal of the confidence reposed." Although this case does not involve physician and patient, it may be observed that the law regards the preservation of the family relationship quite as important as that of the physician and patient.[25]

Common observations, such as may be made by laymen, are not within the purview of the statute. So, our Court has permitted a physician to testify to the general health and mental condition of a person upon whom fraud and undue influence were allegedly exerted, notwithstanding that the person on occasion had been a patient of the witness.[26]

In insurance litigation, it sometimes becomes important to prove that the assured had prior to his application been under medical treatment. In a number of cases involving life insurance policies, where representations as to previous health had been made by the assured in the application, our Court has allowed the attending physician to testify as to the number and dates of professional visits for treatment of the assured.[27]

In at least one case under similar circumstances, the doctor was permitted to testify that he had treated the assured for typhoid fever at some time prior to his making the application for insurance.[28]

Similarly, in an action for injury to his knee, allegedly occasioned by a defect in a sidewalk, plaintiff admitted that he sustained a prior injury to the same knee, but that he had recovered from it at the time of the second accident. The defendant denied this claim, and produced the plaintiff's physician, who testified that he had treated the plaintiff for his prior injury, that he had not been discharged from treatment by the plaintiff, but that he had refused to attend him further because of the calling of another physician without his consent. The Court held that such testimony was admissible and not prohibited by the statute.[29]

Generally speaking, the information obtained by a physician from an autopsy, even if the decedent was in his lifetime a patient, is without the purview of the privilege statute for the obvious reason that it is not concerned with "treatment."

Although the admissibility of doctor's memoranda and records concerning treatment of a patient are subject to the same rules and limitations as his spoken words, there are many records bearing on treatment and physical condition which by express statutory provisions and decisions of our Court are held to be admissible. Important among such admissible records are those of hospitals (except state mental hospitals) made in the usual course, regarding transactions, occurrences, or events which transpired at the hospital in the course of the patient's treatment or care.[30] Likewise, death certificates, birth records, and certain other required official reports from physicians, such, for example, as those which are filed in probate court concerning the condition of mentally ill, feeble-minded and epileptic, are held admissible during litigation.[31]

And so by means of introducing such records,

24. *Scripps* v *Foster,* 41 Mich. 742, 748.
25. *O'Toole* v *Ohio German Life Ins. Co.,* 159 Mich. 187, 193.
26. *Steketee* v *Newkirk,* 173 Mich. 222.
27. *Polish Roman Catholic Union* v *Palen,* 302 Mich. 557; *McKinney* v *Liberty Life Ins. Co.,* 263 Mich. 490; *Dittrich* v *City of Detroit,* 98 Mich. 245.
28. *Brown* v *Metropolitan Life Ins. Co.,* 65 Mich. 306.
29. *Dittrich* v *City of Detroit* supra
30. C.L. 1948 617.53; M.S.A. 27.902 (Enabling amendment added in 1935).
Gile v *Hudnutt,* 279 Mich. 358.
31. *Mulvena* v *Alexander,* 278 Mich. 265.

the privilege statute is completely stultified. Whereas the doctor who makes the death certificate is prohibited from testifying as to the cause of death, and a physician or surgeon may not disclose on the witness stand details of his treatment of the patient while in the hospital, these facts may quite fully be shown through the simple expedient of introducing the written record.

In addition to the variety of situations referred to above, we have in our state at least two statutes which expressly override the privilege act insofar as the admissiblitiy of certain evidence by physicians is concerned. One provides that "information communicated to a physician in an effort unlawfully to procure a narcotic drug, or unlawfully to procure the administration of any such drug, shall not be deemed a privileged communication."[32] The second is a statute which declares it a felony for persons afflicted with syphilis or gonorrhea to marry. It provides that "in all cases arising under this act any physician who has attended or prescribed for any husband or wife for either of the diseases above mentioned shall be compelled to testify to any facts found by him from such attendance."[33]

Disclosures Out Of Court

Although a very considerable body of statutory and case law has developed through the years regarding to doctor's duty to keep silent on the witness stand, the disclosures of his patient's medical secrets in the course of daily living has curiously enough received but scant attention from courts and legislatures. There are no statutes requiring doctors to pay damages to patients for the unauthorized divulgence of medical secrets. Reported cases of damage suits under the common law for breach of confidence are extremely rare.

The Supreme Court of Washington once said by the way of dictum that presumably a cause of action would lie against a physician for wrongfully disclosing a confidential communication.[34] In Nebraska, an action was brought against a physician under interesting circumstances. The defendant physician had examined the plaintiff, and, finding the patient to be afflicted with a contagious venereal disease, requested him to leave the boardinghouse where he was living. Later, finding the plaintifl still there, the physician informed the proprietor of the nature of the disease. The plaintiff was forced to leave the boardinghouse, although, in fact, he was not suffering with the disease diagnosed by the physician. The patient sued the physician for breach of the duty of secrecy. It was held that the plaintiff could not recover. The court said that the information gained by the physician from his patient, though confidential, must be given and received subject to certain qualifications. If the patient's disease is found to be of a dangerous and of so highly contagious or infectious a nature that it would necessarily be transmitted to others unless the danger of contagion is disclosed to them, then the physician should be allowed to make so much of a disclosure as is necessary to prevent the spread of the disease. A disclosure in such case would not be a betrayal of the confidence of the patient, the physician acting in good faith without malice, even though he were mistaken in his diagnosis.[35]

In California, a case arose when a physician's statement that the plaintiff patient was suffering from a venereal disease was overheard by a neighbor, who was a casual bystander. The court held that the patient was not entitled to recover damages.[36] In New York, where by statute the disclosure of records of patients in mental hospitals is prohibited, the court held that the wrongful disclosure of such confidence would give rise to a civil action for damages flowing from such wrong.[37] In New Jersey, a statute declares that records of optometrists concerning their patients are confidential, and forbids their unauthorized use. The court held that a violation of this statute gives rise to a civil action for damages, as it would in the case of doctors of medicine.[38]

Execpt the four cases above cited, no other in point has been noted in any American jurisdiction.

A few states have adopted statutes making "wilfully betraying a professional secret" cause for revocation of a license to practice medicine. Michigan and California have such laws. And Michigan is perhaps the only state which by statute also declares such conduct to be a misdemeanor.[39]

The interesting point in this connection is that, although our statute has been in force since 1907, there is no record of a single revocation of license or of any prosecution for such misdemeanor

32. C.L. 1948 335.67(2); M.S.A. 18.1087(2).
33. C.L. 1948 551.46; M.S.A. 25.6
34. *Smith* v *Driscoll,* 162 Pac. 572, LRA 1917C 1128.
35. *Simonsen* v *Swensen,* 177 N.W. 831.
36. *Shoemaker* v *Friedberg,* 183 Pac. 318 (1947).
37. *Munzer* v *Blaisdell,* 49 NYS 2d 915 (1944).
38. *Abelson, Inc.,* v *New Jersey State Bd. of Optometry,* 65A 2d 644 (1949).
39. C.L. 1948 338.53; MSA 14.533

to be found in this state. In any event, our Court has had no occasion to construe the expression "wilfully betraying a professional secret." What the Court would consider a "professional secret" to be, in light of the modern attitude among the lay public regarding disease and its treatment, and the common discussion of the subject in newspapers, magazines, and at ordinary gatherings is, of course, conjectural. But it may safely be said that few people regard their physical ailments and their treatment as secrets, except perhaps in connection with venereal diseases, abortions, and possibly psychiatric conditions. Would the Court ignore the AMA canon of ethics, hereinbefore quoted, which allows disclosures in many instances? Probably not. It is certainly not clear that "wilfully betraying a professional secret" would be tested by the same rules which have been applied to confidential communications under the privilege statute.

Only one reported case has been found in point. It arose in California. A physician wrote a letter to his former office girl, containing references to certain of his female patients, to one of whom he had given general information about sex matters and on others of whom he had performed surgical operations, including a child delivery. The court held that this did not constitute "wilfully betraying a professional secret" so as to authorize the revocation of the doctor's license.[40]

Chafee comments on the anomaly of the law's seeming indifference to medical disclosures other than on the witness stand, saying:

> "Legislatures and courts have been occupied for over a century in closing the physician's mouth in the very place where the truth is badly needed. And yet the much more important obligation of his silence in private life has hardly been considered. In the few instances where honest patients do dread disclosure of their physicial condition by a doctor, their fear is not that the truth may some day be forced from him in court, but that he may voluntarily spread the facts among his friends and theirs in conversation. Yet against this really dangerous possibility the statutes and courts give almost no protection."[41]

May it be that the reason is to be found in a more mature attitude of the public toward problems of human disease and the removal through education of the veil of secrecy concerning matters medical?

40. *McPheeters* v *Medical Examiners*, 284 Pac. 938 (1930).
41. 52 Yale Law Journal 617.

Disclosures Which Must Be Made

Aside from the statutory provisos and overriding legislation referred to above, modifying the original concept of the privilege statute, the Michigan Legislature has from time to time adopted a number of laws which make it mandatory for the doctor to file official disclosures concerning his patients, otherwise regarded as confidential. The general welfare of society has obviously impelled our lawmakers not only to remove the seal from the doctor's lips, but actually to force him under penalty to make known his patient's secrets. A brief review of the principal statutes of this type may be of some interest to the medical profession particularly.

Omitted from the following list are the well known statutes requiring the attending physician to furnish specified information on official forms regarding deaths[42] and births.[43] The required data include diagnosis of cause of death, and, as to birth, considerable matter bearing on the physical condition or pathology of mother and child.

Specially dealt with are records of births out of wedlock.[44] The statute makes it the duty of the physician in attendance to file a particular certificate. As to stillbirths the certificate requires particularization by the physician of the reasons therefor.[45]

It is made the obligation of physicians to report immediately to the chief of police or sheriff cases which he has under his charge or care of persons suffering from any wound or injury inflicted by means of a knife, gun, pistol or other deadly weapon or by other means of violence. Violation of the duty is declared to be a misdemeanor.[46]

Another statute requires the physician to notify the coroner of the death of any person who shall have died suddenly, accidentally, violently or as the result of any suspicious circumstances, and particularly from an abortion, whether self induced or otherwise.[47]

A physician must within ten days report to the department of health on provided forms every case of occupational disease which comes to his professional attention. The form is detailed and demands information as to the nature of the dis-

42. C.L. 1948 326.9; M.S.A. 14.229.
43. C.L. 1948 326.12; M.S.A. 14.232.
44. C.L. 1948 326.12; M.S.A. 14.232.
45. C.L. 1948 326.15; M.S.A. 14.235.
46. C.L. 1948 750.411; M.S.A. 28.643.
47. C.L. 1948 773.19; M.S.A. 28.1187

ease and a variety of other confidential matter.[48]

Antenuptial examinations are made by statute the essential responsibility of the physician. The problem, of course, is to determine whether the parties to the proposed marriage, or either of them, suffer from a venereal disease. A proper certificate following the examination must be signed and delivered by the physician.[49]

Every licensed physician is required to give notice in writing on forms furnished by the state commissioner of health and pursuant to regulations of the health department of every case of any form of venereal disease which comes under his professional guidance. The report must be made within twenty-four hours of the time that the physician determines that the patient is so afflicted.[50]

Under another special statute, every practicing physician is required, within twenty-four hours, to notify in writing the health officer of his community of every case of any form of tuberculosis which comes under his professional observation. The notice must be made on blanks furnished by the state commissioner of health and shall contain such information as may be required by the commissioner.[51]

Under yet another statute, a physician is required under penalty to report immediately all cases of smallpox, cholera, diphtheria, scarlet fever, or any other disease dangerous to public health, which is brought to his professional attention. Regulations of the state department of health, made pursuant to statute, list sixty-six communicable diseases, including dog bite, as covered by the statute. Recently, cancer has been made a reportable disease, although obviously not communicable. Cases of persons suspected of having such diseases must also be reported. The manner of reporting and the extent of information to be furnished are clearly set forth in the regulations of the department.[52]

The Afflicted Children's Act provides that any child under twenty-one years of age, married or unmarried, who is afflicted with a physical defect or illness which can be remedied, including acute fracture, or who is pregnant, shall be deemed an afflicted child. If a physician has under his care an afflicted child, he is expected to notify a representative of the Crippled Children's Commission or the probate judge. Upon investigation of the circumstances, the physician or surgeon is required to make a written certificate concerning the condition of the child.[53]

The statute which permits secret marriages by the probate judge in cases of unmarried pregnant women provides that the judge may in his discretion require a certificate from a duly licensed physician that the applicant, according to an examination made by the physician, is pregnant. And, if so requested, it would be the duty of the physician to make the examination and certificate accordingly.[54]

Pursuant to the statute dealing with cases of insanity, feeble-mindedness and epilepsy, the probate judge before whom the determination is made is required to appoint two reputable physicians to examine the person involved, concerning his alleged state of insanity, feeble-mindedness or epilepsy. Should a doctor accept such an appointment, it becomes his duty to make under oath a certificate as to the mental condition of such person and file the same with the probate court. The report so filed becomes an official court record and may, as has been pointed out earlier in this article, be used in collateral litigation.[55]

48. C.L. 1948 419.1; M.S.A. 17.431.
49. C.L. 1948 551.151; M.S.A. 25.25.
50. C.L. 1948 329.202; M.S.A. 14.345(2).
51. C.L. 1948 329.401; M.S.A. 14.361
52. C.L. 1948 327.44; M.S.A. 14.104.
53. C.L. 1948 722.305; M.S.A. 25.442(2)(5).
54. C.L. 1948 551.201; M.S.A. 25.51
55. C.L. 1948 330.20; M.S.A. 14.810.

HIPPOCRATIC OATH

The modernization of the Hippocratic Oath by the World Medical Association, known as the Declaration of Geneva (1948), is known to very few and is worthy of note. It runs—

Now being admitted to the profession of Medicine, I solemnly pledge to consecrate my life to the service of humanity. I will give respect and gratitude to my deserving teachers. I will practice medicine with conscience and dignity. The health and life of my patients will be my first consideration. I will hold in confidence all that my patient confides in me. I will maintain the honor and noble traditions of the medical profession. My colleagues will be as my brothers. I will not permit consideration of race, religion, nationality, party politics or social standing to intervene between my duty and my patient. I will maintain the utmost respect of human life from its conception. Even under threat I will not use my knowledge contrary to the laws of humanity. These promises I make freely and upon my honor.

Opinion Evidence from Medical Experts

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WHEN medical experts feel the impact of legal rules of evidence, a clash of professional philosophies results to create an aftermath of criticism of both lawyer and doctor.

For the public is profoundly interested in the consequences of expert medical opinion evidence.

In all actions for personal injury or death, as well as in will contests, insanity proceedings, and many criminal cases, the complex medical questions which arise can be addressed only to doctors who are experts in their profession, with the accuracy and honesty of their opinions being of paramount importance to litigants, as well as to the bench and bar in the administration of justice.[1]

Of those who feel that criticism of lawyers and doctors is justified, it is observed that a claimant's lawyer is too energetic in pressing upon the attending physician the seriousness and permanency of his client's injuries, whereas the defendant's lawyer is interested only in minimizing these injuries, two differing methods of approach which the honest, conscientious doctor resents.[2]

The Lawyer Shifts the Issue

In answering this complaint of the doctor, the lawyer employs a familiar trial technique, and shifts the issue to the doctor, complaining that the doctor fails in his approach because of his own professional pride, and, even, conceit in his skill—a conviction that he never achieves (medically or surgically) *anything but a perfect result!*[3]

As a rejoinder, an eminent medical-legal expert has said:[4]

"No one ever saw an ignorant, incompetent or crooked expert clamoring at the door of the court room for admission to the witness stand as a witness. The lawyers put them there."

Quite so! But, the lawyer has a word, too, in language of an early decision of the Michigan Supreme Court, speaking of the medical expert:[5]

"The physicians were called in, not to give medical aid but to make up medical testimony; and the declarations were made to them while engaged in that work. It would be difficult to find a case more plainly within the mischief of the excluding rule."

An author-doctor, however, taking lawyers to task, wrote:[6]

"I learned that the game is to cause you to swear that you will tell the truth, the whole truth and nothing but the truth and then the lawyers battled to see to it that you did not do either of the three things you were under oath to do."

But, he observed, as explanatory of a lawyer's human frailty:[7]

"At the same time you cannot blame them for there seem to be doctors available for testifying to anything a lawyer may wish them to do."

A Doctor Resents Affront to His Skill

With reference to the observation that a doctor frequently resents being questioned about the permanency of injuries, as a reflection upon his method of care or the results obtained, a discerning trial judge has commented:[8]

"Frequently, there is a serious question in a personal injury trial as to the permanency of injuries to the person. The attending physician has done his best. Too frequently, however, the attending physician resents any suggestion or inference by the attorney for the claimant that permanent injuries may or could result from the accident. Is this due to a misunderstanding of the lawyer's motives, or to a feeling of professional pride on the part of the physician who resents the inference of permanent injury as a personal affront to his professional ability?

"In appraising the injury, and in determining whether there is a degree of permanence, the doctor should realize that his patient, who is one with the lawyer's client, has the right to have his case presented once, and only once, to a judge or jury. Conceding that the attending physician has provided the best possible professional care, there still may exist the reasonable probability of permanent injury. In such case, the lawyer's proposal of a careful scrutiny of the question of permanent injury should not be resented. If the doctor makes a mistake

1. Oscar T. Toebaas, 1952-3 President, Wisconsin Bar Association, at Michigan State Bar Summer Institute, July 24, 1925.
2. *Medical Evidence*, by D. V. W. Beckwith, presented at the Legal-Medical Institute, Milwaukee, Wisconsin, April 22, 1950, Wisconsin Bar Bulletin (August, 1950).
3. Id.
4. Dr. William C. Woodward, *Journal of the American Medical Association*, October, 1932.
5. *Grand Rapids & Indiana R. Co.* v. *Huntley*, 38 Mich. 537 (31 Am. Rep. 321).
6. Dr. Arthur E. Hertzler, *The Horse and Buggy Doctor*.
7. Id.
8. Hon. Lucien F. Sweet, Judge, Ninth Judicial Circuit, Kalamazoo, Michigan: Address before 1952 Joint Meeting of Kalamazoo Bar Association and Kalamazoo Medical Academy.

about the matter of permanent injury, his own patient will be denied the right of full recovery, to experience forever after both serious and pecuniary loss."

Search for Criticism Breeds Only Distress

Forays in search of plunder of criticism will avail the lawyer or doctor nothing but distress. Eventually the lawyer will recognize that he sorely needs the expert opinion evidence of the doctor, and the doctor will sense that the public expects him to play his part in the administration of justice.

Surely, in an action for personal injury or death, a plaintiff should have competent expert medical evidence to aid his recovery of compensable damages, just as a defendant should be protected from a fraudulent or exaggerated verdict by the same kind of reputable expert testimony. While the doctor may suggest that "to know the lawyer is not to love him," he may find comfort in learning why rules of law make their impact upon his expert opinion evidence in a court room!

Why Circumscribe Expert Opinion?

Why, then, are legal restrictions placed upon the reception of expert medical evidence? One brief summary gives as its opinion:[9]

"The objection most consistently voiced to exclude expert opinion is that such testimony 'invades the province of the jury.' This technical phrase embraces two circumscribing limitations upon the use of expert testimony: (1) that the witness shall not be allowed to make statements which rest implicity upon his estimate of the weight of the evidence and the credibility of other witnesses and (2) that the witness shall not be permitted to express his opinion upon matters which constitute the ultimate facts in issue. The results which have attended that application of the rule excluding testimony which invades the province of the jury frequently appear to be inconsistent with the basic purpose of expert testimony. This situation led one eminent writer to say, 'The apparent purpose of the rule might have been supposed to be (by one unacquainted with our jurisprudence) to exclude testimony in proportion to its significance and directness; and the wonder often is how a jury can under the circumstances come to an intelligent conclusion without the aid of banished testimony.' This anomalous result, together with the contrariety of rulings existing even in the same jurisdiction, render profitable an investigation into the operation of the rule, its present status, and its soundness."

It is pertinent that the term "expert testimony" does not embrace all species of opinion evidence, but refers solely to the opinion testimony of witnesses who are permitted to testify because of their special qualifications, and whose testimony must be elicited by hypothetical questions incorporating all the facts upon which the expert is asked to give his opinion.[10]

Judicial Distrust Greets the Expert

One author has commented that, "another manifestation of the judicial distrust of experts is the set of rules in some states placing severe restriction upon the testimony of doctors who have examined the plaintiff not for the purpose of treating him as a patient, but for the purpose of preparing himself to testify about his injury."

This authority observes, further:[11]

"Certainly it is good practice and in furtherance of justice for parties to call in such doctors, frequently specialists, to supplement the testimony of the attending physician who is usually not a specialist and is frequently an unpractised and inadequate witness. But the courts in Texas, Illinois, Wisconsin and Washington and perhaps in other states, by what seems a rather questionable rule, have decreed that the doctor employed not to treat but to testify must be limited to giving his opinion based solely on the objective facts observed by him (or upon a hypothetical question), and is barred from giving an opinion based even in part upon what the patient told him about the history of his injury or his sufferings and symptoms."

Michigan Exclusion is Strict Rule

Michigan, as remarked earlier,[12] has always excluded testimony of an *examining physician,* who is not the *treating physician,* in attempting to relate a case history obtained from the plaintiff. In a later case, the Michigan Supreme Court, in considering the objection to introduction of the testimony of a specialist in nervous diseases, whose examination of plaintiff was for the purpose of coming into court and testifying, and not for the purpose of treatment, remarked:[13]

"The doctor realized the history of the case upon which he based his opinion or conclusion was hearsay. He testified:

" 'That is true, that is all hearsay. But it is the only way you can get a history, checking up for the different tests. She tried—seemed to make an honest effort to co-operate.' "

9. 26 *Iowa Law Review,* p. 819.

10. McKelvey, *Evidence* (4th ed. 1932) Sections 155, 156; *DeGroot* v. *Winter,* 261 Mich. 660; *Kennedy* v. *Bay City Taxi Cab Company,* 325 Mich. 668.

11. *Louisiana Law Review* (March, 1952, p. 265), Charles T. McCormick, Prof. Law, Univ. of Tex.

12. Id., Note 5.

13. *Layton* v. *Cregan & Mallory Co., Inc.,* 269 Mich. 574, 579.

Hearsay Evidence Tempts Dishonesty

In ruling that this testimony of the expert, relating an opinion based upon a case history he had obtained from the plaintiff, was hearsay, the Court quoted with approval language from *Grand Rapids & Indiana R. Co.* v. *Huntley,* 38 Mich. 537 (31 Am. Rep. 321), which sufficiently persuades of the danger of permitting hearsay testimony as a basis for expert opinion:

> " 'The physicians here were not called in to aid or give medical treatment. * * *
>
> " 'They were sent for merely to enable the plaintiff below to prove her case. The whole course of the plaintiff was taken to no other end. She had in her mind just what expressions her cause required. They were therefore made under a strong temptation to feign suffering if dishonest, and a hardly less strong tendency if honest to imagine or exaggerate it. The purpose of the examination removed the ordinary safeguards which furnish the only reason for receiving declarations which bear in a party's favor. * * *' "

Scientific Information is Not Hearsay

In regarding the Michigan rule excluding hearsay testimony of this character, it should be noted that a case history obtained by an expert who examines the plaintiff for the purpose of giving testimony, and not for the purpose of treatment, does not come within the known exceptions to the hearsay evidence rule,[14] whereas an expert's knowledge of his fellow scientists' reported data, learned by perusing their reports and journals, has usually been regarded as an exception to the hearsay rule.[15]

Relation of subjective symptoms of the plaintiff to the examining physician, who is preparing to testify, may not be related by the physician on the witness stand; but, Michigan courts do permit a plaintiff to testify to his own subjective symptoms,[16] and an attending physician may also testify to subjective symptoms,[17] such statements of pain as described by witnesses being admitted into evidence upon the ground that they are "the natural and ordinary accompaniments and expressions of suffering," without which "it would be impossible in most cases to know of the existence or extent or character of pain. . . ."[18]

14. 41 *Columbia Law Review,* p. 1257; *O'Dea* v. *Mich. Cen. R. Co.,* 142 Mich. 265.
15. 2 Wigmore, *Evidence* (3d ed. 1940) Sec. 665 (b).
16. *Reck* v. *Whittlesberger,* 181 Mich. 463.
17. *Leedy* v. *Hoover,* 160 Mich. 449; *McDuffie* v. *Root,* 300 Mich. 286, 295.
18. Id., Note 5; *Rogers* v. *City of Detroit,* 289 Mich. 86, 90.

Spontaneous Declarations Are Admissible

It should be remarked that these spontaneous declarations of pain by the plaintiff, made in the presence of witnesses, are admitted into evidence, as *acts,* rather than as *declarations,* this rule never having been extended in Michigan so as to include declarations either of past suffering or of the causes in the past of such suffering, and thus to make such statements proof of the facts.[19]

It would appear, however, that the Michigan rule has been relaxed somewhat to permit the physician who examines the plaintiff solely for the purpose of testifying (while not being able to relate statements made by the plaintiff during the course of his examination), to testify to exclamations or manifestations of pain occasioned by his clinical examination, such as, a "tender area in the palm."[20]

"Stop, Look, and Listen"

One writer has erected a "Stop, Look, and Listen" sign which may be of value to the physician who has examined the plaintiff not for the purpose of treatment, but only to testify:[21]

> "I think it advisable to warn the doctor, when he is examining a party for the purpose of giving testimony only, that he should not base his testimony or his opinion on any statement made by the party to the doctor in the course of the examination. I have a number of times seen the testimony of doctors entirely stricken because they were unable to give an opinion which was not based in part at least on the subjective symptoms related by the patient, and their examination was not made with the rule in mind that their opinion could not be based in any degree on the subjective symptoms related to them."

Confining this discussion, at this point, to the presentation of expert testimony from a physician employed only to testify, several requirements of the law should be considered.

As previously noted, the expert testimony of such physician must be elicited by hypothetical question.[22]

Hypothetical Question Foils the Expert

Now, the doctor will most certainly believe that the hypothetical question was designed to prevent him from giving his testimony as a smoothly-flowing, consecutive, detailed presentation, and, after listening to the arguments between opposing at-

19. Id.
20. *DeVries* v. *Owens,* 295 Mich. 522, 529.
21. Id., Note 2.
22. Id., Note 10.

torneys about the legal hurdles which circumscribe hypothetical questions, he will probably agree with an eminent legal text writer, that, "The hypothetical question, misused by the clumsy and abused by the clever, has in practice led to intolerable obstruction of truth."[23]

One legal writer observed:[24]

"* * * Moreover, the hypothetical question is a comparatively ineffective way of presenting the expert's conclusions to a jury. And a long one is a real soporific! Reading a speech is bad, but how much more entertainment did the jury get from a question in a California court which covered eighty-three pages of typewritten transcript, followed by an objection covering fourteen pages."

While testimony of an expert nature may be adduced from a professional or skilled observer from inspections he has made, without the use of hypothetical questions, the hypothetical question must be employed where the expert's knowledge of facts is gained from other sources or persons, and, consequently, would be hearsay.[25] Not having the requisite personal knowledge of the truth of the facts, he should not be permitted to testify directly about them.

Fair Sampling of Facts is Presented to Expert

Clearly, the hypothetical question need not embrace all of the testimony in the case; but, the "opinion of the witness may be taken on any combination of facts which counsel may believe the jury will find to be established by the proofs."[26]

Nor must all of the facts assumed by the attorney propounding the question be free of dispute. While, frequently, objection is made that the hypothetical question contains statements which are untrue and unsupported by testimony, such dispute does not render the question improper, if the question fairly states such facts "as the proof of the examiner tends to establish and fairly presents in support of his claim or theory."[27]

Question to Expert Must Issue From Truth

Necessarily, however, *all of the facts and circumstances* recited by the examiner in his hypothetical question, upon which the medical expert is asked to base his opinion, *must be found to be true* by the jury, or trier of the fact, otherwise, the "answer of the witness is without probative force and must be disregarded by the jury,"[28] and, *a hypothetical question known to be based upon facts not shown by the evidence may be excluded.*[29]

Commencement of the hypothetical question is usually by a requirement of the examiner, such as, "Now, Doctor, assume that a young man, twenty-six years of age . . . ," or, less frequently, "Now, Doctor, supposing . . . ," or, even, "Now, Doctor, consider . . . "[30]

"There Might or Could Be" A Relation of Cause and Effect

After relating the material facts and circumstances upon which the opinion of the witness is desired, the expert is asked (in Michigan) as to whether the medical expert has an opinion, based upon a reasonable medical certainty, as to whether there *might* or *could* be a causal relations between the cause of injury and the result found.[31]

As explanatory of this restriction of the expert,[32] the Michigan Supreme Court, speaking through Mr. Justice Wiest (*DeGroot* v. *Winter,* 261 Mich. 660, 670-671), has employed this language:

"Expert opinion evidence is an exception carved out of the general rule confining a witness to a relation of facts, and is usually accomplished by means of hypothetical questions.

"Upon the issue of whether defendants were guilty of malpractice by commission or omission the expert could and did give opinion evidence. Upon the ultimate issue of whether plaintiff's condition resulted solely from malpractice, the expert should not have, but did give his conclusion as to a fact, not necessarily following malpractice, and in dispute. When a result may or may not be occasioned by malpractice, an expert medical

23. 2 Wigmore, *Evidence* (3d ed. 1940) Sec. 686.
24. Id., Note 11.
25. *O'Donnell* v. *Oliver Iron Mining Co.,* 273 Mich. 27, 36.
26. *In Re Rosa's Estate,* 210 Mich. 628, 640; *Bishop* v. *Gaudio,* 266 Mich. 267, 269; *Bosch* v. *Damm,* 296 Mich. 522, 529.
27. Id., Note 25 (pp. 36-37).
28. *Bosch* v. *Damm,* 296 Mich. 522, 529.
29. *People* v. *Bowen,* 165 Mich. 231.
30. *Trial Technique,* Irving Goldstein, p. 454.
31. *De Haan* v. *Winter,* 258 Mich. 293, 300; *DeGroot* v. *Winter,* 261 Mich. 660, 671.
32. Id., Note 11, pp. 272-273: "A few states, however, have retained the prohibitory rule, as applied to expert testimony as to cause, in a form so extreme that it is surprising that it should ever have been seriously defended. This is the view that the doctor may not testify that in his opinion the accident did cause the present disability, but may only answer the question, 'Can you say whether in your opinion it *could* or *might* have caused the injury?' As has been pointed out, this restriction is unfair to the expert. If he answers yes, the jury may believe that his opinion is no stronger than a belief in the *possibility* of causal relation, whereas in fact the doctor may be convinced that the accident *was* the cause, but is not allowed to say so. Moreover, if he should answer *no,* it could not have been the cause, the answer would offend the court's canon, for it would clearly be an opinion on the issue."

witness invades the province of the jury when permitted to go beyond stating that it *could,* and in saying that it *did,* occasion the result. Such an opinion is but the private judgment of the witness and not competent evidence. Whether the alleged malpractice could occasion the result complained of was one of science only. Whether malpractice did occasion such result was in controversy, and, therefore, not one of mere science. When the facts are admitted and not in dispute, the question, if answered, may be considered one of science. But when a result could have been occasioned by one of two or more causes, the ultimate fact of which cause occasioned the result is for determination by the jury, and a medical expert may not, in case of conflicting evidence, invade the province of the jury and testify that the result was in fact occasioned by one cause only.

"Rules of evidence should have stability. The rule violated in this case was early announced by this court, repeatedly followed, supported by the weight of authority, has led to no injustice, and has kept medical experts from invading the province of the jury and should be maintained."

In the earlier case of *De Haan* v. *Winter,* 258 Mich. 293, 300, Mr. Justice Wiest, in giving the opinion of the Court, declared that the medical expert could only go as far as "to state that the alleged malpractice of defendant *might* cause the bow in the leg." (Emphasis supplied.)

Future Results of Injury Determined by Expert Testimony

Reasonably probable future consequences of an injury, as discussed heretofore,[33] being of paramount importance to the injured person, will be determined by the jury upon the opinion evidence of medical experts, adduced by direct or hypothetical question, depending upon whether he is called as an expert to testify upon a matter of hypothesis, or whether he is testifying as an expert observer of the bodily condition, and with the knowledge and history of the patient, gained as the attending physician.[34]

In *Pearce* v. *Rodell,* 283 Mich. 19, the Michigan Supreme Court, speaking through Mr. Justice Potter, in considering whether an expert medical witness, who had been given an opportunity to observe and examine the patient, was competent to testify to the extent of a certain injury, whether the injury was permanent or not, and the probable results of the injury, said, at pages 31 to 33:

" * * * The opinion of a medical man is admissible upon the condition of the human system, and upon the probability of recovery from an injury, or upon other questions peculiarly within his knowledge as such. . . . So, it is said a physician is competent to give his opinion as to the probability of recovery generally. . . . He may give his opinion that physical injuries are, or are not, of a permanent character. . . .

"In the case here, not only did the physicians testify very fully as to the facts upon which they based their conclusions, but they were entitled to give the opinion which they did give on the probable effects of the injury which plaintiff received. The probable effects of an injury such as that suffered by the plaintiff could be shown only by the opinion of a competent physician. . . ."

An Expert Witness is Not a Jury

It is the Michigan rule that an expert witness may not be permitted to base his opinion upon the testimony of other witnesses in the case, since the effect of such questioning would be to require the witness, and not the jury, to pass upon the credibility and correctness of previous testimony.[35]

Nor may an expert medical witness be permitted to give an opinion as to the credence to be given the testimony of *other experts* who testified in the case, since this, too, would be invading the province of the injury.[36]

Medical Textbooks Are Not Evidence

Use of medical textbooks as evidence is quite generally prohibited in all jurisdictions, although, on direct examination, a doctor may mention the name of a text, as supporting his opinion.[37]

While this mention of a text may subject the medical expert to cross-examination based upon the particular text,[38] an examiner on cross-examination may not question an expert about text authority which has not been injected into the case.

Reason for this latter rule of law can be gleaned from the opinion of the Michigan Supreme Court, in *Sykes* v. *Village of Portland,* 193 Mich. 86, 102-103:

"In *People* v. *Millard,* supra, this Court said:

" 'Another source of error quite as mischievous, * * * was the introduction of what is no more than hearsay evidence, in the shape of references to writers and books in such a way as to invoke their authority. As we have had occasion on more than one record to explain heretofore, expert testimony is only admissible on the theory that the jury cannot be supposed to comprehend the significance of facts shown by other testimony

33. Id., Note 8.
34. *Pearce* v. *Rodell,* 283 Mich. 19, 30; *Bishop* v. *Gaudio,* 266 Mich. 267, 269: ". . . . reasonable certainty of future probable consequences of injury."
35. *Kempsey* v. *McGinnis,* 21 Mich. 123, 140-141; *O'Donnell* v. *Oliver Iron Mining Co.,* 262 Mich. 470, 474.
36. *In Re Elliott's Estate,* 269 Mich. 677, 686.
37. 6 Wigmore, *Evidence* (3d ed. 1940), Sec. 1700; 82 A. L. R. 440.
38. *De Haan* v. *Winter,* 258 Mich. 293, 299; *De Haan* v. *Winter,* 262 Mich. 192, 196.

which needs scientific or peculiar explanation by those who do not comprehend it. But this does not permit hearsay testimony of the written or spoken opinions of other persons, whom the jury have no means of examining as to their learning, their honesty, or their sources of special knowledge.' "

Even more pertinently, from the standpoint of the medical witness, *People* v. *Millard,* 53 Mich. 63, 75-76, pointed out:

" * * * No one can tell whether a medical book or opinion is reliable or not, until he has applied himself with some fitting preparation to its study and criticism. The book may be good in part and bad in part, and neither court nor jury can presumptively ascertain its quality."

Lawyer Examiner May Possess Guile

Both of these decisions which are quoted condemn the familiar device of lawyers of reading excerpts from text authorities into evidence, under the guise of cross-examination or of ascertaining the familiarity of the expert witness with such texts, in the hope that the purportedly contrary opinions may persuade the jury to disregard the testimony of the witness on the stand.

Obviously, since opinions on many questions of science are so constantly undergoing change, it is impossible to know at the time of trial whether the author of a text still entertains the views which he expressed in his writing.[39]

While it is a common practice for doctors to base their diagnosis upon their own clinical examinations, supplemented with x-ray examinations interpreted by expert radiologists, with biopsies performed by technicians, and with blood, sputum and urine tests conducted by assistants and reduced to written reports, it is quite apparent that such examinations and tests conducted by strangers may not be used by the expert medical witness in giving his opinion, if objection to their consideration is raised.

Must Produce X-Ray Films

In a recent case, *Kennedy* v. *Bay City Taxi Cab Company,* 325 Mich. 668, the Michigan Supreme Court held that it was error to permit a treating physician to relate his conclusions from x-ray films, as to what the x-ray disclosed, without producing the films upon which his testimony was based, or without explaining the non-production of the films.

And, in *Mapes* v. *Berkowitz,* 304 Mich. 278, reference to the results of some apparently non-existent blood tests (there was some testimony of taking blood from the plaintiff), which were incorporated in the hypothetical question, brought about a striking of the question from consideration of the jury, the Supreme Court affirming a directed verdict. Quoted transcript of the trial indicates that the trial judge, in ruling on the objection, said:

"The elements of this question are not supported by the testimony in the case, that is all the Court can rule, and being a hypothetical question, there must be some testimony to support each claim in the question or it cannot be submitted. In fact on a hypothetical question the jury have to find from the evidence that each element in the question is supported by the evidence, not only intimated, so they can find that has been established, there are several elements that the testimony doesn't form a basis for. If you have testimony to show what was done at the hospital, put it on, let us know what it is."

Final Test of Expert is Finding of the Jury

Finally, while the weight and sufficiency of expert opinion evidence is for the jury, or trier of fact, to decide, according to the same tests which apply in the scrutiny of all other evidence in the case, it should be noted that if the jury finds, from all of the evidence in the case, that the facts stated in the hypothetical question are not true, then the jury may disregard the *entire answer* to the question.

There is no way of partially salvaging the good of an opinion which is based upon faulty underpinning!

In *Thornton* v. *Berry,* 259 Mich. 529, the Michigan Supreme Court, speaking through Mr. Justice McDonald, at pages 531 and 532, said:

" * * * The answer of the expert assumes the facts asserted in the question to be true, and if they or any one of them are not true the answer is worthless as evidence. *Ballance* v. *Dunnington,* 241 Mich. 383."

Non-Resident Experts Welcome to Michigan

Michigan, unlike some other states,[40] has no statutory prohibition against medical experts of the several states giving opinion evidence in Michigan. And, its courts seem to treat non-residents with the same courtesy extended to Michigan medical experts. In *Sampson* v. *Veenboer,* 252 Mich. 660, an Illinois physician, with a considerable background of study in Germany, and conducting of small hospitals at Chicago, Illinois,

39. Id., Note 2, p. 13.

40. Id., Note 2.

seemed to ingratiate himself into the Court's affection by his flattery of the standards of surgery in Grand Rapids (Michigan), and his testimony was acceptable (by hypothetical question) in a malpractice action against a Grand Rapids surgeon. The verdict and judgment for plaintiff was reversed on other grounds.

Wisconsin and Michigan—A Matter of Opinion

In a Wisconsin case (*Morrill* v. *Komaskinski,* 256 Wis. 417), the action of the trial court in permitting a *Michigan osteopathic physician* who treated the plaintiff to testify against a *Wisconsin medical doctor* in a malpractice case was approved; but, in *Bryant* v. *Biggs,* 331 Mich. 64, the Michigan Supreme Court held that the testimony of a *medical doctor,* as an expert witness, was not competent for the purpose of proving alleged malpractice of an *osteopathic physician.*

Expert Witness Must Qualify

It is axiomatic that the qualifications of the expert witness must be shown. Unless the qualifications are waived, no presumption exists that the expert is qualified.

In *People* v. *Hawthorne,* 293 Mich. 15, defense counsel sought to qualify a college professor as an expert to give testimony about insanity. The professor had received degrees of bachelor of arts, master of arts, bachelor of divinity, doctor of philosophy, and doctor of psychology; he had studied at eight different colleges, and had taught at four; he had given courses in general psychology; he had written books on psychology, and he had given "mental tests."

The Michigan Supreme Court, however, held that insanity was regarded as a disease, and within the realm of medical science. "Only physicians," the Court said, "can qualify to answer hypothetical questions as experts in such science."

Number of Experts Limited—as Well as Witness Fees!

While, perhaps, of little significance, there is the statutory provision, that[41]

"No more than three (3) experts shall be allowed to testify on either side as to the same issue in any given case: *Provided,* The court trying such case, may, in its discretion, permit an additional number of witnesses to testify as experts."

With respect to fees which experts shall be paid, we find the special statute:[42]

"No expert witness shall be paid, or receive as compensation in any given case for his services as such, a sum in excess of the ordinary witness fees provided by law, unless the court before whom such witness is to appear, or has appeared, awards a larger sum, which sum may be taxed as a part of the taxable costs in the case. Any such witness who shall directly or indirectly receive a larger amount than such award, and any person who shall pay such witness a larger sum than such award, shall be guilty of contempt of court, and on conviction thereof be punished accordingly."

On the other hand, ordinary witnesses receive for attending in any suit or proceeding, pending in a court of record, $5.00 for each day, and $2.50 for each half day, in addition to traveling expenses of ten cents a mile.[43]

One of the most vexatious factors in the relation between doctors and lawyers is the matter of fees. When a doctor testifies only to facts which are not the subject of expert testimony, he is not entitled to compensation as an expert witness. He is then in the same category as an ordinary witness. One who gives expert medical evidence, however, as an opinion based upon his learning and experience, is entitled to receive the compensation of an expert witness.[44]

Despite His Loss, The Lawyer Pays

Moreover, in the interest of lawyers, it should be remarked that some doctors make a habit of charging the plaintiff's attorney for reports about the plaintiff, who is also the doctor's patient, when the plaintiff's attorney is handling the case on a contingent basis. Frequently, the doctor will not be paid his charges for treatment and surgery if the plaintiff's attorney is not successful in his litigation. Thus, it would seem that the attorney was, in reality, working for the doctor, and, that if the case is finally lost, the attorney might reasonably bill the doctor for his legal services in the same amount that the doctor bills the lawyer for testifying![45]

This would be a *set-off in good conscience!*

Court to Appoint Experts Under Proposed Legislation

House Bill No. 90 has been introduced in the Michigan Legislature, as a product of a special committee of the Detroit Bar Association which

41. 1948 Compiled Laws, Sec. 617.70 (Mich. Stat. Ann. §27.919).
42. 1948 Compiled Laws, Sec. 617.69 (Mich. Stat. Ann. §27.918).
43. 1948 Compiled Laws, Sec. 648.3 (Mich. Stat. Ann. §27.2557).
44. Id., Note 8.
45. Id.

has the approval of the State Bar Committee on Civil Procedure.

This bill, to amend Chap. 17 of Act No. 314 of the Public Acts of 1915, provides for the appointment by the court, in any civil proceeding, where a dispute arises between experts, either on motion of the court, or at the request of either party, one or more experts to investigate such issues and to testify at the trial.[46]

The bill introduced in the House is identical to the State Bar proposal, except for the one word, "Not," which has been eliminated. In the State Bar proposal, the provision read: "The fact that such witness or witnesses have been appointed by the court shall NOT be made known to the jury."

This bill may serve the public demand for greater harmony in medical opinions, following, as it appears to do, the rules of expert opinion evidence adopted by the Committee on Evidence of the American Law Institute, in its *Model Code of Evidence,* published in 1942. It may, however, run afoul of certain legal entanglements.

Workmen's Compensation Provision Was Declared Unconstitutional

It may be recalled that the Workmen's Compensation Act, Part VII, Sec. 6, which was added by Act No. 61 of the Public Acts of 1937 (Comp. Laws Supp. 1940, §8485-6, Stat. Ann. 1945 Cum. Supp. §17.225), was, as follows:

"In case the employe is alleged to be suffering from an occupational disease and there shall be a dispute with respect thereto, the said board, or any member thereof, shall appoint a commission of three qualified impartial physicians to examine the injured employe and to report. The report, when signed by at least two of the members of said commission, shall be final and conclusive as to the condition of said employe with respect to the alleged disease or diseases. Members of the commission shall receive such compensation for their services as shall be fixed by the board, to be paid from the appropriation to the department of labor and industry."

This statute worked quite effectively (!) until April, 1946, when the Michigan Supreme Court declared it unconstitutional, in *Dation* v. *Ford Motor Co.,* 314 Mich. 152. Admittedly, the "final and conclusive" feature of the report was objectionable, there being no requirement with reference to notice, nor attempt to safeguard a fair hearing, but the point is, at the time the bill was passed, it seemed to be the solution to a problem, and considerable legislative and public discussion was had about its merits.

Public indignation may well be upon the march, as it becomes aroused at the failure of expert testimony to mold itself into a pattern, but its travel should be narrowed into constitutional roadways!

Another provision of the Workmen's Compensation Act, initially enacted, in 1912, in substantially the same language, is:[47]

"The compensation commission or any member thereof may appoint a duly qualified impartial physician to examine the injured employe and to report. The fee for this service shall be $5.00 and traveling expenses, but the board may allow additional reasonable amounts in extraordinary cases."

There is no safeguard in the statute as to the manner in which this report is to be received into evidence, although the statute is but rarely invoked by the Commission in adversary proceedings.

The former statute requiring an employe to submit himself to periodical physical examination to determine the existence of occupational dust diseases, under penalty of being deprived of benefits of the Workmen's Compensation Act,[48] was declared unconstitutional by the Michigan Supreme Court, in *Foundry Workers Union* v. *Foundry Co.,* 321 Mich. 265.

(Continued on Page 428)

46. "Chap. 17. Sec. 69A. Whenever, in a civil proceeding, a dispute arises between experts, the court on its own motion, or on the request of any party, may appoint 1 or more experts, not exceeding 3 on each issue, to investigate such issues and to testify at the trial. Such expert witness must be appointed from a panel designated by the society, association, board or similar organization in his profession or field, and the compensation of such person or persons shall be fixed by the court at a reasonable amount and paid as directed by the court. The fact that such witness or witnesses have been appointed by the court shall be made known to the jury. Any party to the proceeding may also call other expert witnesses.
"Experts called by the court or by the parties in the proceeding shall be permitted access to the persons, things or places under investigation for the purpose of inspection and examination.
"An expert witness may be asked to state his inferences, and these may be stated as a fact, whether these inferences are based on the witness' personal observation, or on evidence introduced at the trial and seen or heard by the witness, or on his technical knowledge of the subject, without first specifying hypothetically in the question the data on which these inferences are based. An expert witness may be required, on direct or cross-examination, to specify the data on which his inferences are based."

47. 1948 Compiled Laws, Sec. 413.9 (Mich. Stat. Ann. §17.183).

48. Act No. 318 of the Public Acts of 1945 (Comp. Laws Supp. 1945, §8485-4, Stat. Ann. 1947 Cum. Supp. §17.223).

Malpractice as Seen by a Lawyer

By Clayton C. Purdy, A.B., LL.B.

Detroit, Michigan

THE TERM "malpractice" applies to a great many types of cases, but in the minds of lawyers and physicians it usually refers to actions against the medical profession only. Few lawyers, and not many medical men, thoroughly understand the conditions under which a physician, surgeon or dentist may become liable for improper treatment of a patient. Because of this lack of knowledge, a great number of cases are improperly instituted against members of the medical profession.

The definition of the duties of a physician or surgeon is well set forth in the old case of Gillette v. Tucker, 65 N.E., 1865, wherein the court stated:

> "A surgeon and physician, employed to treat a case professionally, is under an obligation, which the law implies from the employment, to exercise the average degree of skill, care, and diligence exercised by members of the same profession, practicing in the same or a similar locality, in the light of the present state of medical and surgical science and that he will indemnify the patient against any injurious consequences which may result from his want of ordinary skill, care, and attention in the execution of his employment."

This statement, we believe, embodies all of the elements that courts usually set forth as the duties of the physician and surgeon to his patient.

In order for a plaintiff to prove a malpractice case, the following steps are necessary:

1. He must prove there was a legal duty to perform.
2. He must prove a failure to perform that duty.
3. He must prove an injury which is directly traceable to the breach of duty, namely proximate cause.

The great majority of cases predicated on malpractice grow out of the assumption that there was negligence or failure to do, or not to do, the thing which the condition of the patient required should, or should not, be done. We should say at the outset that a bad result is no evidence of negligence. Yet, in ten out of twelve cases the layman, and not too infrequently the physician himself, mistakes a bad result for conclusive evidence of negligence. To say that more than 60 per cent of the cases predicated upon malpractice are the result of this misconception of the law would be a most reasonable statement. The condition usually starts with the dissatisfaction of the patient. The patient, being dissatisfied with the results, consults another physician; that physician sees the bad results but has not the history of the case, nor does he have the picture of what the original physician faced at the time he first saw the patient. But, in too many cases, without having all of these facts before him, he will presume to say what should have been done, and which, if done, would have produced a different result. Inadvertently, or thoughtlessly, or for some other reason, the physician criticizes the work of his fellow practitioner and helps to nurture the seeds of discontent which were already in the patient's mind. This results in the grievance being magnified and eventually leads the patient to institute an action as the only possible satisfaction of his claimed injury. Moreover, it is my observation that the thoughtless or inadvertent criticism of one physician of the work of his fellow physician has been the cause of the majority of the unwarranted malpractice actions. It is very easy to build up your own reputation at the expense of the other fellow—and this equally applies to the legal profession, although there, for some reason, a malpractice action is not usually the result.

Such a state of affairs is unfortunate for the medical profession. In spite of all precautions taken, or how capable and diligent the doctor may be, mistakes will occur and errors in judgment will be made, which of themselves are no foundation for a cause of action.

The following illustrates a remote cause of difficulty that could well be blamed on the doctor.

> In a small midwestern city, during a severe winter, when ice-covered walks and streets, for weeks at a time, caused an unusually large number of fractures, difficulty was experienced by the medical profession with plaster casts. The plaster used would not sufficiently harden to maintain reduction of the bone fragments. Investigation was instituted and finally a representative of the

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gypsum company which had furnished the material found an error in the technique of mixture which accounted for the trouble.

As long as doctors are willing to criticize the work of their fellow practitioners, judging only from results which can be seen and the statements of the patients, we must expect malpractice actions to continue to increase. Before embarking upon the criticism of the work of fellow practitioners, doctors should make sure that they have been given correct statements of the conditions which prevailed at the time treatment was administered, and they should remember at all times that physicians are not guarantors of their work—they only agree to bring to the patient such skill and knowledge as they possess, and to apply that skill and knowledge in accordance with the usual and ordinary practice of physicians in that or similar communities. If they honestly apply such knowledge and skill as they possess, and yet make a mistake or commit an error, they are not liable for malpractice, even though the patient may suffer as a result of such mistake or error.

Results Not Guaranteed

The law seeks to be fair in defining the standard of care and skill and does not require nor ask the impossible. In the absence of a special contract, a doctor is never considered as warranting a cure or guaranteeing that his treatment will result in a benefit to the patient. He is not responsible in law for want of success unless it can be shown to be the result of the lack of ordinary care and skill in the treatment of the case.

A patient suffering from an eye malady consulted a doctor, who operated on the eye. The patient alleged that following the operation she suffered great pain in the eye and finally lost the right eye entirely and suffered an impairment of the sight of the left eye. The court in finding for the doctor said:

"The naked facts that defendant performed operations upon her eye, and that pain followed, and that subsequently the eye was in such a bad condition that it had to be extracted, establishes neither the neglect and unskillfulness of the treatment, nor the casual connection between it and the unfortunate event. A physician is not a warrantor of cures."

Agents

Ordinarily, one is responsible for his own conduct only, but physicians may be legally charged with responsibility for injurious consequences resulting from the conduct of a third person by reason of his relationship to them. Probably a doctor's most frequent contact with others than those in his own office comes from his practice in hospitals. In this respect he is intimately associated with nurses, interns, and others employed to render the usual hospital care, and he is dependent upon their services. It is manifest that a hospital renders a professional service separate and distinct from that of a doctor and we are all familiar with the high degree of efficiency of the staffs of the modern hospitals of today. This requires that hospitals employ and train their own nurses, interns and orderlies to discharge the duties required of them according to the recognized technique in that community. Generally speaking, such employes are servants of the hospital and are not considered to be employes of the doctor treating the patient in the institution. From this comes the rule of law that an operating surgeon should not be held legally responsible for the negligence of hospital nurses or employes unless the hospital is owned or controlled by him. This proposition is frequently met in suits involving alleged negligence in postoperative dressing of wounds, hot-water bottle burns, use of the wrong or too hot solution in administering a proctoclysis, and innumerable other types of injuries. If the damage occurs from a negligent act of a hospital employe while performing a regular duty arising out of and in the course of his employment with the institution, as distinguished from the performance of some special act under the immediate direction and control of the surgeon, no liability attaches to the doctor.

We must point out, however, that the law deals largely with exceptions to the general rule and we find the courts enlarging or restricting this rule or its application in order to reach a desired result in a particular case. The prevailing opinion that charitable hospitals are not liable to patients for injury occurring through the negligent acts of hospital employes is a further impetus to courts to establish liability on the doctor, as a means of providing for the patient's financial recompense. Constant effort and vigilance are required to oppose the ever broadening responsibilities which courts are prone to place upon the medical profession to the relief of other agencies, such as nurses, hospitals and laboratories, all of whom contribute something to the intricate system of medical care.

In an attempt to properly recompense the pa-

tient some courts as early as 1923 adopted the so-called "Loaned Servant Doctrine." This doctrine held that employes under the doctor's direct supervision, even though he was unable to actually observe what they were doing, made him responsible; and even though they were hospital employes, they were considered as loaned to the doctor for the purposes of the operation. The first statement on this doctrine was as follows:

"While the head nurse and her assistants were the general employes of the sanitarium, they were, nevertheless, during the time required for the actual operation, under the direction and supervision of the operating surgeons, and were the servants of the operating surgeons in respect to such services as were rendered by them in the performance of the operation, and for any negligence on the part of such employes in the performance of such services the operating surgeons are liable."

It is questionable that under the present intricate proceedings used in performing operations that such a doctrine has any solid foundation on which to stand. Operations today are planned and organized and the various parties participating therein are trained especially for their duties and it seems unreasonable that the surgeon should be held liable for negligent acts of others who are not his employes, and over whom he can exert no supervision because he is using all of his time and effort on the very serious and involved details necessary in performing major surgery.

Generally, the responsibility for maintenance of equipment—operating tables, instruments, beds, etc., is upon the institution and the physician is not held liable for such equipment unless through exercise of ordinary care and skill he could observe some defect and would, therefore, be negligent in accepting the same.

All illustration of the above is a case which was heard some years back in Detroit:

A patient was having a carbuncle removed from the back of his neck. This required that he be placed face down on the operating table. As an electric cautery knife was to be used in the operation, it was necessary to place an electrode between the abdomen of the patient and the operating table. It was the custom for the resident to prepare the patient and the cautery knife in readiness for the surgeon. This was done by the resident while the surgeon was "scrubbing up" for the operation. The operation proceeded and when it was completed and the patient returned to his room, it was found that his abdomen was very seriously burned, apparently due to faulty contact of the electrode. A malpractice suit was instituted against the defendant surgeon. We were able to show that the resident placed the electrode in position so that the electric cautery knife could be used. We were also able to show that even if the surgeon had investigated to see that the electrode was in proper position, thereby rendering himself unsterile through having to move the patient, there was no assurance that while he was again "scrubbing up" the electrode would not become displaced. On the basis of the testimony and the fact that the resident was in the employ of the hospital and a part of his duties was to make the preliminary preparations for operations where the electric cautery knife was to be used, the judge directed a verdict in behalf of the defendant surgeon.

There are, of course, many exceptions to the general rules discussed here and cases could be cited indefinitely, but this gives a general picture of the situation as it exists at the present time.

Substitutes

Another situation in which the agency question arises is when a doctor takes a vacation or when his calls conflict so that he cannot be in two places at the same time. What arrangement is best under such conditions and what liability is imposed upon the doctor for the acts of one who substitutes in his place? This is of vital concern to the practicing physician and cases can be found to support many different points of view.

One of the earliest opinions in this country in which this question was decided was handed down by the Supreme Court of Michigan in 1878. In this case the action was against a surgeon retained by a railroad to treat its injured employes. While this surgeon was out of town an employe was injured. Before leaving town, the surgeon had notified the superintendent of the railroad of his impending absence and gave him the name of another doctor who could be called to treat any injured employes during his absence. When the injury occurred, the patient was referred to the doctor recommended by the company surgeon. When the surgeon for the railroad returned he took over the case. The question arose as to whether or not he was responsible for alleged negligent treatment of the case by the substitute doctor. The court said:

"It was right and proper that the physician of the company, when about to be absent for a few days, should inform the company of his proposed absence and recommend some other person to take his place, should occasion require, until his return. This would be equally true of a family physician about to go away for a short time. There would be nothing more natural

or proper than for him, before going away, to give notice of the fact and recommend some suitable person to be called during his absence. Yet no one would think of considering the person so recommended, if called, as acting under the employment of the physician who recommended him. It is not claimed that there was any express agreement between the two doctors under which the company physician agreed to pay the recommended substitute physician for any such services as he might be called upon to perform, and certainly the facts as appearing upon this record would not raise an implied promise."

Consent to Operations

A physician in performing any operation must have the consent of the patient, either express or implied, and certainly for the physician's protection it should be in writing. Physicians are dealing daily in matters that involve substantial sums of money. If something goes wrong, and there is but the implied or verbal consent of the patient, the doctor is taking a desperate chance. The patient can always change his mind or his testimony after a suit has been instituted. In my experience I have never found a bank that would loan money without taking a note from the borrower, no matter how well it knows him and no matter what an excellent reputation he enjoys. It seems to me that in the nature of things, written consents to operations are just as necessary, because the courts have generally held that an operation performed without consent is tantamount to assault and battery.

The courts have held that a man of legal age, although very ill, may consent to an operation and that it was not necessary to obtain the consent of his wife. They have also held that it is necessary to obtain the consent of parents before an operation can be performed on a minor. A case in Michigan a few years ago is of interest in illustrating this point:

> In that case the plaintiff, a normal boy of nine and one-half years, was taken by a school nurse to the City Physician on suspicion of infected tonsils. The City Physician sent him to a private hospital with a memorandum requesting removal of his tonsils. The boy was accompanied to the hospital by his fifteen-year-old brother and his tonsils were removed by the defendant in the case. The testimony showed that the parents did not know of the operation until it had been performed and their testimony also showed that they had repeatedly stated they did not want the child's tonsils removed. This, of course, was not known to the doctor as it was presumed by him that the parents were perfectly satisfied inasmuch as the City Physician had sent him for this operation. Tonsillectomy is ordinarily a simple operation, but in this case because of hemorrhage, the boy was kept in the hospital and in getting up during the night he fell and struck his head against some object and became totally blind. The court, after considering all of the facts involved in the case held that the operation was unlawful because it was without the consent of the plaintiff's parents and constituted an assault upon plaintiff, for which defendant was liable.

As can be seen from this case even the simplest matter may turn into very substantial damages.

The court made the following statement in another case which we think sets forth the law very clearly:

> "Where a patient is in possession of his faculties and in such physical health as to be able to consult about his condition, and no emergency exists making it impracticable to confer with him, his consent is a prerequisite to a surgical operation by his physician; and a surgeon who performs an operation without his patient's consent, express or implied, commits an assault for which he is liable in damages."

As I am writing this article, there is considerable publicity to the effect that many unnecessary operations are performed. In my experience, I can truthfully say that I have never run into such a situation, although undoubtedly that does happen on occasion. There are unquestionably unethical practitioners in the medical profession as there are in all professions, but we do not think that the few cases which may be turned up should indict the profession as a whole. Each case presents an individual problem and the surgeon must use his best judgment.

It would seem that it is better not to restrict the physician in the exercise of his best judgment, even if it later appears that a few operations which were performed may not have been necessary. If the doctor is to be so restricted, because of the possibility that if he is wrong he will have to respond in damages, he will be inclined to be extremely cautious, and that could result in necessary operations not being performed. There is a point where only the doctor can make the decision for or against an operation and if he uses his honest judgment there should be no penalty, even though it is later claimed he was mistaken in his decision.

For several years the writer gave a course in "Medical Jurisprudence" at the Wayne University College of Medicine. One of the questions given

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Psychiatry and the Courts

By George K. Swartz, M.D.

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THERE has been a definite need for the combined services of psychiatry and the legal profession in the prosecution of criminals. The legal and medical professions always have had much in common; both deal with the problem of human behavior, in caring for individual needs and the adjustment of individuals to the mores of society. The medical approach to this problem has been preventive, and the treatment of mental aberrations, while the legal interest has assumed a more protective role. The courts have adopted a paternalistic function, being both protective and punitive.

Since the time of their inception, the courts as a whole have functioned well. The Federal Bill of Rights has been our standard of conduct, guaranteeing our liberties. The courts of the land, through the power provided, have zealously guarded our individual liberties. The state mental health laws were written to conform with the Federal Bill of Rights—a part of our National Constitution, which declares and affirms that no one shall be deprived of his liberty without due process of law. This law was devised in order to protect individuals from being incarcerated without an open and just trial. In others words, no one is to be considered guilty and punished for guilt until he is proven guilty through a fair trial. There is a limitation on the time that a person may be detained. Even though our laws are just and excellent, they are not perfect. There have been times when these laws did not fit the occasion. As yet, no adequate way has been found to meet the emergencies that have arisen regarding the mentally ill. Periodically there are horror stories, reported in the news. We are told of demented persons who become killers, running berserk through the streets. A description of these killers usually points out that previous to their criminal outburst their behavior had been sufficiently bizarre that it had been noticeable to neighbors, and their sanity had been questioned. Because of our adherence to our principles of liberty for all, these individuals are permitted to go their way unchallenged. No examination is made to determine sanity until such a person has committed some misdemeanor, felony, or crime.

In this matter it would appear that the laws have been static or reactive. Certainly, with our collective inventive ingenuity, some means or variation of the law could be devised in order that a demonstration of abnormal behavior would at least call for an investigation. The individuals with the abnormal behavior could be examined and kept under observation until it is established whether or not they have ideas or attitudes that might result in harm either to themselves or to others. Another way in which the courts appear to have been rigid in their interpretation of the law is their insistence of a jury trial for the committing of the insane persons to a mental institution. The assumption is that the individual is being deprived of his liberty against the wishes of the individual (which may or may not be altogether true). It may be merely that the courts are fulfilling a ritual in complying with the "due process of law." The letter of the law must be carried out and that, in the mind of the court, is the chief requirement.

The last fifty years have seen our population doubled. During that time cities and villages have grown. Suburbs have come into being and the congestion of humanity has multiplied. Should this growth continue until the end of the century, certain definite regulations will have to be provided to better handle thickly populated areas. Provision will have to be made for a closer supervision of the mentally abnormal in our population. At the turn of the century our people were more independent socially and economically. Each family and community was independent, almost entirely unto itself. Then, when a member of a family showed "queer traits," they were placed in a secluded area of the home and cared for by the family. Today, with smaller homes, less help, and less independent family groups, those persons who show abnormal behavior must be hospitalized early. These economic and social factors make it appear that liberalization of restraining laws should be provided in order that greater expediting may be accomplished in the hospitalization of the mentally ill.

Another means for protecting the individual from being deprived of his liberties is the Writ of Habeas Corpus. This writ seldom, if ever, need be used, as it was originally intended. A law that demands the presentation of a body at the

call of the court, in the case of the mentally ill, is seldom if ever needed. Possibly, in the past, such cases occurred, but today it is practically impossible for the insane to be held as hostages, after they have regained their sanity. Probably, years ago, when the so-called "normal" population was more sadistic in its attitude toward others, keepers of the insane could use them for a source of revenue by providing a perverted type of amusement. Today, mental hospitals are overcrowded. The least attendant at an institution is able to advance his opinions publicly, regarding patients and their treatment. It is practically impossible, today, to hide away a mentally sound person, and there are few, if any, who would risk a highly improbable scheme of this sort, trying to banish or sequester someone for a price or a ransom.

Most mental hospitals are under the supervision of a State Department of Mental Hygiene. The question then arises why the courts, and some judges, still insist that the ill present themselves in court for commitment. Prior to the establishment of State Departments of Mental Hygiene, it would seem that precaution should be taken, but now, under state supervision, there is little risk of irregularities. The courts do have the choice of not requiring the insane to appear in court, if it is considered harmful or detrimental to the health of those applying for committment. Frequently, the court procedure is very distressing to the individual and only in extreme circumstances should a patient be required to appear in person.

In investigating and supervising individuals, the courts want the truth. To whom can they turn for assistance, regarding health problems, but to the medical profession. Psychiatrists are well trained in their branch of medicine, but yet, at times, in court they appear to be inaccurate and lacking in agreement. There have been minor differences because of a lack of standardization. Heretofore, our psychiatric ideas were based upon European concepts. Gradually, an American School of Psychiatry is being established, and with it there will be a uniformity of definitions. There will be none of the semantic differences that occur in the translation from one language to another. Before psychiatrists can be completely effective in the courts there must be a standard language describing the components of disease and resultant anticipated actions and reactions of the mentally ill. The court seeks and needs information regarding competency. Whether or not the person is able to protect himself and his property judiciously, is information the court must have. Another loophole in our supervision of the mentally ill is that no guardians are appointed until after a petition has been asked to declare an individual mentally ill or weak-minded. In cases where mental deterioration has gradually progressed, accompanied by loss of insight and judgment, fortunes may be squandered or loosely arranged contracts drawn, before legal protection can be arranged.

There is the general impression that the feeling between the medical and legal profession has not been co-operative. It has been advocated that effort be made to improve this association. There are rumors that the legal profession has not looked kindly upon having members of the medical profession in court. The medical profession has resented the attempts of the legal body to "trip them up" while testifying in court. These divers attitudes can be changed if there is a sincere effort to correct past conduct. The following suggestions would seem indicated, viz.: While in court, the physicians should remain scientists, and not attempt to take over the work of the lawyers. They should remember that their duty is not to try to influence the court, but only to present the facts. When several physicians are testifying, they shall be in agreement as to diagnosis and prognosis. To accomplish this, it might be necessary to discuss the case before the hearing and arrive at a similar opinion, so that there will be no differences in court in spite of the protests of opposing lawyers. There should be a uniformity of meaning and definitions. The language used should be chosen carefully so that it can be understood by every juror present.

During a discussion of a case, there should be no open disagreement between members of the medical profession. If, and when, members of the medical profession deport themselves in that manner, they have reason to expect to be accepted more graciously by the legal profession in court. The members of the bar will cease being on the defensive and lose their aggressive attitude, knowing well that there is no hiding or clouding of the facts.

The greatest problem of the courts is to arrive at a correct estimate of the intellect and emotional stability of those arrested on a criminal charge. There had been a growing belief that the main

bulk of the criminals were either defectives, constitutional psychopaths, or pyschotic. The question kept arising, which should be detained in a penitentiary and which in mental hospitals. There had been much surmising, but no actual facts, until in 1921 when there was enacted in Massachusetts, the Briggs Law. This law was acclaimed as an important piece of legislation. It provided for the investigation, by an impartial psychiatric examination, of those accused of serious or repeated crimes. This law was intended to stop the flow of ricidivists of penal institutions, recognize the importance of attempting to understand a chronic offender, and make available to the courts impartial psychiatric opinion, before the state had gone to the expense of a trial. Weihofen[8] reported that the statutes in at least twenty states and the Federal Rules of Criminal Procedure now expressly authorize the trial courts to appoint medical experts to examine the defendant and make a report.

Regarding certain sexual perversions, there are divers opinions among psychiatrists as to their baneful influence on society. Rickles[6] classifies exhibitionism as a profound neurosis, with little if any harmful influence, and with no assaultive tendency on the part of the exhibitionist. Voyeurism is a frequent symptom of schizophrenia and mental deficiency. In several European countries homosexuality is no longer classified as a punishable offense. A certain number of biologists are of the belief that homosexuality is a constitutionally determined condition and not the result of exposure or experience. There has been considerable discussion, with the matter unsettled as to the etiology of the constitutional psychopath. Penitentiary populations contain many criminals who have been classified as psychopaths. The question remains whether the psychopath's acts, which are sometimes violently antisocial and criminal, are the result of subconscious compulsions. Up to the present time they are held responsible for their acts and consequently do not come under the M'Naughton Rules. Occasionally, there is need for the examination of a plaintiff. It is especially imperative when a child or woman accuses some male of spurious sex advances. The shades of the Salem Witchcraft still linger in the wings of the drama of society.

The essential points of the M'Naughton Rules are, viz.: To establish a defense on the ground of insanity it must be clearly proved that at the time of the committing of the act the party accused was laboring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing what was wrong.

After enactment of the Briggs Law in 1921, several studies were made of the findings of that law. In 1935, W. Overholser[5] pointed out between 10.6 per cent and 25.7 per cent of those arrested on criminal charges, showed mental abnormalities.

A case study[1] from the files of Sing Sing Prison, of 102 sex offenders of various types, showed that none could be classified as normal.

M. Guttmacher,[2] in an article on the medical aspects of the causes and prevention of crime, stated that from a fifth to a third of the offenders showed important psychiatric abnormalities.

P. Hagopian[3] analyzed the findings of 6,591 cases in Massachuetts. All of these cases were subsequent to the enactment of the Briggs Law. It was learned that of these criminals, 98.7 per cent were male, 1.3 per cent were female. The type of offense ran the gamut from murder to bootlegging, and impersonating an officer. There were 620 sex offenses— or approximately 10 per cent, and of these offenders 97.9 per cent were male, 2.1 per cent were female. In the examiners' opinions, of the total number of cases in this study, 5,339 (81 per cent) of the accused did not suffer from any mental defect or disease. The opinions expressed regarding the remaining 1,252 (19 per cent) were classifiable in the following manner:

Definitely psychotic, 82 (1.2 per cent).
Recommended for observation in a mental hospital, because of mental symptoms, 403 (6.1 per cent).
Feeble-minded, 361 (5.5 per cent).
Borderline, 353 (5.4 per cent).
*Other conditions (psychopathic sexual), 53 (.8 per cent).

Any group of criminals, of which 19 per cent show mental abnormalities, should be enough to convince those interested that laws similar to the Briggs Law should be enacted by all of the States.

Lebensohn,[4] in a thoughtful article, makes a plea for a closer rapport between psychiatrist and

*Usually psychopathy is not recorded because, as previously stated, psychopaths are held responsible for their acts.

lawyer. He believes that there is mutual distrust and suspicion. He attributes these reactions to ignorance of each other's functions, objectives, and basic philosophy, and urges wider dissemination of knowledge as a remedy. This attitude appears to be a healthy approach to solving the problem, but there are other means that could help rectify the matter.

In the study of psychiatry, and in psychiatric textbook material, emphasis, as it should be, is on psychopathology, diagnosis and treatment. There are short chapters on sensorium, intellectual resources, judgment and insight. Chapters on the subject of the investigation of criminals will need to be incorporated in all standard textbooks.

The courts are not interested in diagnosis. They are interested only in whether or not there is evidence of mental abnormality. They want to know the degree of competency, responsibility or accountability. They do not want to hear a lot of irrelevant medical phraseology or terminology. On the other hand, the testifying physician does not enjoy being irritated by a categorical "yes" or "no" answer to a question demandingly put to him by a prosecuting or defense attorney, when the question cannot be honestly answered by a simple "yes" or "no."

Too often there is the sorry dilemma of an accused man being legally sane, but medically insane. Now what is the solution to this problem? E. Strecker[7] offers several solutions. He believes that the M'Naughton Rule is archaic. The determination often rests on the flimsiest criteria. He believes that through the co-operation of legal and medical societies in various sections of the country, panels of competent psychiatrists should be formed; the psychiatrist being willing to serve at the request of the judge in any given case, and with the consent of the prosecutor and defense council. Such impartial testimony could not be suspect, and it would carry great weight. His second plan would have to be implemented by new legislation. In it, psychiatric experts would examine an accused thoroughly. He (or they) would observe at a trial, but would not testify. The guilt, or innocence, would be decided by the jury, judge, prosecution, and defense. Then the psychiatrist would be authorized to have an important voice in the decision concerning the degree of responsibility, and the nature of the corrective punishment, or treatment.

Another plan that might be devised would be to have representative committees from the American Bar Association, the American Medical Association, and the American Psychiatric Association, formulate rules and plans for the examination of criminals. This examination would be sufficiently comprehensive to satisfy the courts regarding mental impairment, competency, responsibility, and accountability. Qualified psychiatrists would make the examinations in an impartial objective manner, and the report would then be sent to the judge assigned to the case, to be used by the court in arriving at a verdict and the type of treatment or punishment that should be handed down. Whichever method is chosen, it will improve relations between the legal and medical professions, and justice may more accurately be meted out.

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MEDICAL CARE COSTS

In a sample survey of sixteen cities of different sizes, U. S. Bureau of Labor Statistics has found the *moderate-income* families contacted spent between 4.7 per cent and 6.4 per cent of their total expenditures on medical care. The study, made in 1950, is part of a larger survey of spending in ninety-one cities which the BLS conducted in connection with a revision of the government's cost of living index. The index will be changed starting next January, bringing it more in line with present-day spending habits. Some 16,350 families were checked in the ninety-one cities. The survey listed the following percentages: New York City, 5.9; Chicago, 5.2; Los Angeles, 6.1; Philadelphia, 5.1; Boston, 4.7; Pittsburgh, 4.7; Minneapolis, 5.7; Kansas City, Mo., 5.1; Portland, Ore., 5.2; Canton, O., 5.1; Charleston, W. Va., 6.0; Lynchburg, Va., 6.4; Grand Forks, N. D., 4.7; Ravenna, O., 4.8; Pulaski, Va., 5.4; and Madill, Okla., 4.7.

In commenting on the sixteen-city survey on medical care spending, BLS cautioned that the sampling in some localities was small and that it excluded *upper-income* and *rural* families.

Provisions of the Michigan Laws Regarding Adoptions

By Barrett Lyons
Lansing, Michigan

THE PLACEMENT of children for adoption is subject to various laws and regulations designed to protect the legal rights and the well-being of all of the persons concerned, but primarily those of the children.

Many physicians at some time or other will be asked by a mother to find an adoptive home for her baby, or by a childless couple to find a child for them. Since physicians are not always aware of what their rights and legal responsibilities are in relation to such requests, this article is intended to outline the various possibilities. This is followed by a discussion of current practices which are questionable and concludes with a statement of certain clearly illegal activities in which the physician may unwittingly find himself involved.

The Michigan adoption law[1] recognizes two ways in which a child may be placed for adoption:

1. The natural parent or parents or the child's legal guardian with the approval of the probate court may make a direct arrangement with the adopting parents to place the child with them.
2. The juvenile division of the probate court which has through legal process taken custody of the child, or an authorized private or public child-placing agency to which the child has been committed by the court or released by the natural parents, may place the child for adoption. When the placement is made by the court or by an agency, the natural parent need not know where the child is placed.

An authorized private agency is an agency licensed[2] by the State Department of Social Welfare to place children in foster homes.[3] The Michigan Children's Institute at Ann Arbor is the only public child-placing agency authorized to place children for adoption.

Whether the child is placed by his parent or guardian, by the court or by an agency, the adoption statute prescribes that certain procedures must be followed. First, before accepting the child into their home the adoptive parents must file a petition with the probate court. If after investigation the court finds that the home is suitable, that the child is physically and mentally a proper subject for adoption and that "the best interests of the child will be served by such adoption," an order is made terminating parental rights and authorizing placement of the child. One year after this order, the court may make the order completing the adoption. This one-year period may be waived by court order "if the best interests of the child will be served thereby," or may be extended if circumstances make this desirable. When placement is made by an authorized child-placing agency, the agency gives supervision during this waiting period and shares responsibility with the adopting parents and the court if anything goes wrong before the adoption is completed.

There are two ways in which the physician may legally act as the go-between for the mother of the child, and the foster parents, without the mother knowing who the latter are. The first possibility is to become the guardian of the baby. Such a guardianship is legally possible, generally speaking, only when the baby has "no father or mother living, competent and suitable to have the custody and care of the education of such minor."[4] However, this language covers most of the situations where the mother wants to have her child placed for adoption. The physician may make application in the probate court to be appointed guardian of the child, requesting in his petition the right to consent to an adoption. Immediately thereafter the family he has chosen as parents for the baby should petition the probate court for adoption of the child and file with the petition the consent of the physician to the adoption. After the court is satisfied as to the propriety of the proposed adoption, it would issue an order terminating parental rights and the guardianship. However, in the interim, this type of action places full responsibility upon the physician for deciding to act in the interest of the baby.

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1. The adoption law. Chapter X, Act 288, P. A. 1939, as amended. (Chapter 710, C.L. 1948, as amended.)
2. The child-placing agency and foster home licensing law. Act 47, P. A. 1944, First Extra Session, as amended. (Sections 722.101-722.108, C. L. 1948, as amended.)
3. There are sixty-eight licensed child-caring agencies, but not all of them are licensed to place children for adoption. A directory of the licensed agencies is published by the State Department of Social Welfare.
4. Section 1 of the guardianship law. Chapter III, Act 288, P. A. 1939, as amended. (Chapter 703, C.L. 1948, as amended.)

The other method, not known ever to have been used in Michigan, is somewhat similar. The physician would apply to the Department of Social Welfare for a license to be an authorized child-placing agency. The department maintains standards for child-placing agencies which the physician would have to meet, but once licensed, he would be able to have babies released to his custody by their mothers and to place them for adoption. The court procedure thereafter is the same as above.

A third variation is possible in a few counties where the judge of the juvenile court is willing to accept original as well as final responsibility for the placement upon the recommendation of the physician. In this situation, the physician asks the judge to accept a petition in juvenile court[5] from the mother to take jurisdiction over her child in order to place it in a home selected by the physician. The judge must then have an investigation made, and after such investigation, he himself can have the baby placed and consent to the adoption. However, most judges have lists of approved homes waiting for the placement of children and feel that the physician should not attempt to substitute some home the physician has selected.

Each of these methods is designed to protect the social and legal rights of the child. The physician acting under the first two would be responsible for the child and, in a sense, to the child. Under the law the best interests of the child and not those of either set of parents are paramount.

However, sometimes a physician in ignorance of the law or in the effort to avoid these legal steps resorts to a questionable practice. In this situation, he selects a home for a baby, instructs the foster parents to petition for the adoption giving them all the details necessary to make the petition, and then secures from the mother a direct consent for the adoption of the child while concealing from her the names of the adopting parents or at least their address. In some counties the practice has become common if the probate judge has permitted it. Some physicians have been led to believe that if no money changes hands, there is nothing illegal about it. However, the law states clearly that "No person other than the parent or guardian of the person of a child or one related by blood or marriage, and no firm, corporation, association or organization, or agency thereof, other than a licensed child welfare agency or a governmental unit may place any child in the control and care of any person or place such child for adoption."[6]

In some cases the physician, in the apparent belief that if the mother herself delivers the baby to the adopting parents the requirements of the law are satisfied, has arranged for the foster parents to come to his office or to the hospital to receive the baby from the natural mother, without first taking the necessary legal steps to bring the baby within the jurisdiction of the court and secure authorization for its placement in the adoptive home. Although in this instance the doctor may have protected himself because technically the baby was placed by the natural mother, the foster parents have taken a child into their home in violation of the statutes. When they go to the court to start adoption proceedings, this will be a barrier. Or there may be other legal impediments to the adoption; for example, the child of a married woman may not legally be adopted until the parental rights of her husband have been terminated either by release or by a court order, even though he is not the natural father. And when the case finally gets to the court for action, the mother may have changed her mind about releasing the baby. On the other hand, if she has disappeared, the court must acquire jurisdiction through a petition under the juvenile code alleging that the baby is without proper care and guardianship, which may present complications. In the meanwhile, the baby remains in the foster home with no one legally responsible for him, sometimes no one even knowing with certainty who he is.

Other actions which the physician may take without being aware of the illegality of his acts include the following: He may suggest to a financially needy, pregnant girl that he will be glad to provide his services gratis (or that he knows of a good family who will be willing to pay for them) if he (they) may receive the baby. The adoption statute provides that "No person or persons shall offer, give or receive any money or other consideration, or thing of value in connection with the placing of any child for adoption or in connection with the consent to adoption, or with the petition for adoption except such charges and fees as may be approved by the probate court." Thus, offering a consideration (either money or services) to the mother for the placement of her child be-

5. Chapter XIIA, Act 288, P. A. 1939, as amended. (Chapter 712A, C. L. 1948, as amended.)

6. Section 7 of the child-placing agency and foster home-licensing law.

fore approval of the court is secured is clearly in violation of this statute.[7]

Sometimes an expectant mother agrees with the physician that the child is to be placed and tells him that she does not wish to see her baby, and the doctor so instructs the hospital. There is nothing in the law requiring a hospital to honor the doctor's order not to show the baby to its mother, and if the mother changes her mind this is an unenforceable agreement. It is probable that the mother could recover damages if the hospital attempted to carry out a physician's order in this respect. Only the judge of probate of the court which had taken jurisdiction of the child would have the right to make such an order.

As a corollary of the above two paragraphs, it is evident that it is highly improper for a physician to use the fact that the prospective parents have paid money as an argument to persuade a mother to carry out her original agreement to give up her child.

One serious evasion of the laws designed to protect children available for adoption occurs when a mother enters the hospital wearing a wedding ring and giving her name as that of the prospective foster mother. While this does create a birth certificate which purports to show that the baby is the child of the would-be parents, it does not actually create the relationship and can result in the child's being removed from the foster parents several years later for the reason that they have no legal rights. Sometimes this deception occurs without the knowledge of the physician but suspicion will always rest on him; thus he should be especially careful always to require identification of his maternity patient if there is any reason to be uncertain about it.

One other statute which is of interest to physicians is the act which requires all maternity homes, and hospitals and clinics offering maternity services to be licensed by the State Department of Health.[8] One provision of this act requires the licensee to report by memorandum separate from the birth certificate certain social information regarding illegitimate babies born on the premises, and about all other babies born there if the mother indicates that the child is to be placed. It is illegal for the physician to interfere in this process since these memoranda provide the state with its means of determining that babies have not been disposed of improperly. The law provides that the State Department of Social Welfare assist in this determination. In respect to this law physicians whose connection with any home or hospital is an administrative one should be aware that "No employee or officer and no member of a governing body of any such hospital" (unless the hospital is licensed as a child welfare agency) "shall engage in any activity in connection with placing a child for adoption nor shall such person give out any information about unmarried mothers or their children to any unauthorized person to assist in placing a child for adoption."

The State Department of Social Welfare will be glad to furnish any physician upon request complete copies of the first four laws quoted in this article and of the list of licensed agencies. The fifth law is available from the Health Department. The medical profession is certainly as deeply concerned in assuring effective legal and social protection for children to be placed for adoption and for would-be foster parents as are courts and the public and private child welfare agencies. Such objective includes the providing each adoptable child with a home suited to his particular needs. All this cannot be obtained for all children unless all laws are scrupulously adhered to without exception. By so doing the medical profession will be able to assist in the improvement of the laws to the end that finally only persons genuinely concerned with the rights of children and able to take the responsibility necessary to protect these rights may play any part in placement.

STATUTORY PROVISIONS

1. *The Adoption Law.*—The legal procedures for the adoption of children are set up in Chapter X of the Probate Code.

The first step in the procedure is the filing of an adoption petition by the person or persons wishing to adopt a child. The second step is the signing of a consent to the adoption by the natural parents, unless their rights have been terminated by court action or unless the child has been released by them to a licensed child-placement agency. If the child is a permanent ward of the court no consent is necessary. If the child is in the custody of a placement agency, either by voluntary release from the parents or by court order, a duly authorized representative of the agency must sign the consent.

The probate judge must then order an investigation by the county agent or probation officer, by a licensed-placement agency, or by the State Department of Social Welfare. A written report of this investigation must be filed with the court. If the judge is satisfied as to:

7. Section 13 of the adoption law.
8. The maternity hospital licensing law. Act 263, P. A. 1913, as amended by Act 231, P. A. 1951.

(a) The genuineness of consent to such adoption and the legal authority of the person or persons signing such consent.
(b) The good moral character, ability to support and educate such child, and the suitableness of the home of the person or persons adopting such child for said child.
(c) The mental and physical condition of the child as a proper subject for adoption in said home, and
(d) That the best interest of such child will be served by said adoption.

an order must be entered making the child a ward of the court.

Only after this is done may the adopting parents legally take the child into their home. Section 12 of Chapter X of the Probate Code reads as follows:

"No child shall be placed in any home for the purpose of adoption until an order terminating parental rights and making the child a ward of the court as herein provided has been entered."

One year after the child has been made a ward of the court, the final order of adoption may be entered. This waiting period may be waived if the court finds that the best interests of the child will be served thereby.

2. *The Boarding Home Law.*—Act 47, P. A. Michigan 1944, First Extra Session, which supersedes a similar Act originally adopted in 1913, requires agencies placing children in family homes for adoption or for boarding care to be licensed by the State Department of Social Welfare. It also requires any private home caring for children not related by blood or marriage to be licensed. Section 7 of this statute reads as follows:

"Placement of children in family homes. No person other than the parent or guardian of the person of a child or one related by blood or marriage, and no firm, corporation, association or organization, or agency thereof, other than a licensed child welfare agency or a governmental unit may place any child in the control and care of any person or place such child for adoption."

3. *The Maternity Hospital Law.*—Act 263, P. A. 1913, as amended by Act 231, P.A. 1951, requires the State Health Commissioner to license and regulate maternity and lying-in hospitals in order to assure "the physical and social protection of new-born children." This Act includes the following:

"Every licensee shall keep a register wherein shall be entered the full name and address of each person admitted, the date of admission, the date of birth of every child born on said premises, and such other information as the state health commissioner may require. Every licensee shall also keep a memorandum of the name, age, color and sex and other social information the mother wishes to divulge of every child whose mother has indicated to the licensee or his agent a desire to place such child in foster care, or of a child who was born to an unmarried mother, and shall cause a correct copy of such memorandum to be sent to the judge of probate of the county wherein such hospital is located, if he so requests, and to the state health commissioner within 48 hours after such child or its mother leaves the hospital. The state health commissioner after consultation with the state department of social welfare shall prescribe and furnish each licensee with the forms of records and memoranda herein mentioned. In no case shall any child be placed in any home for foster care or adoption, on trial or otherwise, by any licensee under the provisions of this act, nor in any case unless licensed to do so under the provisions of Act No. 47 of the Public Acts of the First Extra Session of 1944, being sections 722.101 to 722.108, inclusive, of the Compiled Laws of 1948. No employee or officer and no member of a governing body of any such hospital shall engage in any activity in connection with placing a child for adoption nor shall such person give out any information about unmarried mothers or their children to any unauthorized person to assist in placing a child for adoption. The state department of social welfare shall assist in the enforcement of this section and for this purpose may review the said registers and memoranda required by this section."

MALPRACTICE AS SEEN BY A LAWYER

(Continued from Page 405)

on an examination created considerable comment among the class and it seems as though it might be appropriate to recite it here. Although the facts set forth in this question are almost identical with those in a case that arose several years ago, we have changed them a little to bring out additional points. The question of legal liability; the question of ethics; the question of public policy; the question of consent to the operation, and the question of unnecessary operation, are all brought into play.

We shall not attempt to answer the question, but merely set it forth for your consideration.

"A," a sixteen-year-old boy, is attending a summer camp for boys in Northern Michigan. "B," a third-year medical student, is employed as a supervisor at the camp. "A" is taken seriously ill and Dr. "C" is called from a nearby town to treat him. The medical student, "B," examined "A" and determines that he was suffering from an acute attack of appendicitis and should have an immediate operation. Dr. "C," after examination, agrees to that diagnosis, but he refuses to operate until he can get the consent of "A's" parents. An attempt is made to get their consent, but it is found that they are out of the state for a week-end and cannot be reached. A try was made to get another doctor for consultation, but without success. "B" insists that the doctor operate, but he refuses and "A" dies from a ruptured appendix. Is Dr. "C" liable in damages and if so, why?

The Lawyer and the Physician Examine the Question of Traumatic Carcinogenesis

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INCREASING PUBLIC concern with cancer is bringing new problems to the legal and medical professions. That these spheres of interest impinge and overlap in at least one aspect can be seen in cases in which suit is brought to recover damages for the induction of cancer by trauma. One such case is now in the process of litigation at the time of preparation of this paper.

Cancer is now branded as public health enemy Number Two, second only to cardiovascular disease in the number of deaths each year. A small but important portion of the cancer problem is concerned with the possibility of the induction of neoplasm after trauma.

Exploration of this problem necessitates the formulation of basic definitions and approaches to implement a common understanding. "Trauma, a wound; a bodily injury produced by violence,"[11] is expanded by implication to include physical, chemical, thermal, electrical, and ionization forces which may cause damage to the body. Carcinogenesis is the process of inducing fundamental alteration in cells resulting in malignant or cancerous change which eventually destroys the host from whose tissues these cells were derived.

Methods of investigation of the relationship of trauma to the induction of malignant neoplasm are limited. Although man is the principal subject, our humanitarian scruples prevent the use of man for direct experimental investigations, since these would entail calculated destruction of human life. Therefore, the historical medical approach must be used; i.e. the accumulation of clinical observations, the application of the talents of clinicians, pathologists, roentgenologists, physicists and chemists to the common problem; the statistical analyses of these findings, and the ultimate clarification or substantiation of these impressions by controlled animal experimentation. Such conclusions as are reached, by virtue of the nature of the problem, cannot be expressed as mathematical formulæ, but rather as significant trends, i.e., not all roentgenologists ultimately develop leukemia, but it is nine to ten times as frequent in this group as among physicians in general, hence a significant trend.

As Medicine must assume its responsibility to mankind in controlling the ever-increasing number of carcinogenic substances in common use, so it would seem that the Law must be equally concerned with the equitable regulation of conflicting human interests in this field.

The most common and simplest aspect of this question deals with the possibility of physical trauma, acute or chronic, to stimulate carcinogenesis at the local site. Investigators of this problem are in general unanimity that physical trauma —as a blow or repeated blows to an area—is not a cause of cancer formation.[3]

The more complex factors surrounding trauma —other than simple mechanical injury such as a blow or contusion—necessitate careful scrutiny. Clinical reports from competent and independent physicians from widely separated sectors of the world draw attention to the following observations:

(a) An unusually high incidence of lung cancer among the miners of radioactive ore in Eastern Germany.
(b) An historical interest in scrotal cancer in chimney sweeps in England.
(c) An unusual frequency of bladder cancer among certain dye workers.
(d) A statistically significant increase in lung cancer among chromate and asbestos workers.
(e) An increase of skin and scrotal cancer in some groups of shale oil workers.
(f) An increased incidence of skin cancer and leukemia from prolonged exposure to electromagnetic energy.
(g) An increased incidence of leukemia following atomic bombing.

Investigation of the carcinogenetic capacities of chemicals and electromagnetic energy indicates that about 169 of 700 chemicals tested so far are carcinogenic in the broad sense of inducing tumor, and that electromagnetic energy in the form of chronic x-ray exposure may induce neoplastic changes in the skin or mucous membranes.[4]

There is well-established evidence for the recognition of cancer of the lung as an occupational

hazard of the miners of Schneeberg and Joachimstal.[12] However, the unexpectedly high incidence of primary lung cancer is not limited to a small segment of miners working with radioactive ore. The same grave problem has been detected in statistical analyses of other industries. Gregorius presents data on deaths from lung cancer in chromate plant workers in the six major chromate producing companies in America.[7] These data indicate that lung cancer occurred seventeen to eighteen times more often in employes of these plants than in the general population as shown in the Metropolitan Life Insurance Company statistics. Further breakdown of these data tends to incriminate the monochromates as the carcinogenic factor. In 1947, analysis of vital statistics indicated that cancer of the lungs or pleura was the cause of death in 13.2 per cent of 235 recorded deaths of asbestos handlers. In this survey, the incidence of lung malignancy was found to be ten times greater in asbestos workers than in the general population.[13] Subsequently, it was felt this hazard was removed by improved ventilation of the plants. Important as these industrial instances of lung carcinogenic hazards may be, they alone do not explain certain highly disturbing recent trends in cancer morbidity and mortality. Hammond points out that cancer was eighth in the list of causes of death in 1900, with 64 deaths per 100,000 population and second in 1948 with 135 deaths per 100,000 population.[8] Cancer death rates per 100,000 population by age groups are as follows:

Age Group	*Death rates per 100,000*
30-35	22
50-55	216
70-75	860

Further analysis of vital statistics for cancer death rates by sites for white males per 100,000 population indicates that cancer of the respiratory system, excluding the larynx, increased from 4.5 plus or minus in 1933 to 16.5 plus or minus in 1948, a far greater percentage increase than occurred in other forms of cancer. This increase is definitely greater in males than in females, and it occurs in all sections of the country and in most other countries which maintain reliable vital statistics.

Additional information is needed to explain, if possible, this pattern. Wynder presents evidence incriminating tobacco smoking as a carcinogenic agent in primary bronchogenic carcinoma.[15] Although exogenous factors and some occupational exposures—even in the rather remote past—may play a role in lung cancer, they can by no conceivable means explain the general increase in this disease. Analysis of the habits of patients with lung cancer reveals an almost universality of the smoking habit—particularly of heavy or chain smoking. Similar general conclusions were reached independently in the British study by Doll and Bradford Hill. The risk of development of primary bronchogenic carcinoma was estimated from these studies to vary directly with the amount of tobacco smoked.[16]

From the preceding reports and the evidence that bronchogenic cancer is statistically encountered in greater than anticipated frequency in workers exposed to tar fumes, mineral oil mists, chromium dusts, nickel-carbonyl vapors, arsenic dusts and fumes, asbestos dust, isopropyl oil vapors, and radioactive gases and dust, the following criteria for establishment of suspicion of industrial trauma inducing pulmonary carcinogenesis may be considered:[9,16]

1. The suspected occupation should manifest a markedly higher frequency among lung cancer patients than among other patients.
2. The suspected occupation should have a higher than anticipated incidence among all cases of lung cancer.
3. The suspected occupation should be found among those cases of lung cancer who have been non-smokers or nominal smokers.

In the individual presenting the complaint of occupational trauma and cancer, the following criteria may be considered germane to the question:

4. That reasonably recent pre-employment history, medical examination, and, if indicated, chest x-rays indicate freedom from pre-existent pulmonary lesions.
5. That the worker be actually exposed for an adequate time to reasonable concentrations of the carcinogenic substance to permit the induction of carcinogenesis.
6. That the lung cancer in the individual be proved by acceptable pathologic study.

It is significant that the guide of past experience would suggest that the time factor of Item 5 would be in terms of years, and that we have no reliable

standard as regards concentration of the offending agent. It is equally important to consider that individual susceptibility may markedly affect the above.

Routine or periodic cytologic sputum examinations by the Papanicolaou technique on workers in suspected industries should prove to be an effective method of screening employes and of making early detection when curative surgery may be performed.[2] This procedure may be positive where bronchoscopy fails, and it also eliminates the objection to routine bronchoscopy.

Observations from industries of Italy and France cast light on the carcinogenic property of certain dye chemicals on the urinary bladder. Barsotti and Vigliani found statistically significant increased frequency of bladder cancer, papillomas, and congestive lesions in the bladders of workers in dye stuffs plants.[1]

From their meticulous observations, they conclude that benzidine base and beta-naphthylamine have the highest carcinogenic power of the dyes studied; that open systems of processing and handling these materials are especially hazardous; that the minimum time of exposure for a tumor to appear was four years and the maximum twenty-eight years; and that the maximum period between cessation of exposure and the diagnosis of tumor was twenty-eight years. Truhaut surveyed the same problem and reported that among the carcinogenic pure chemicals are those that have the capacity for inducing malignant tissue change at a distance from the portal of entry.[14] The predilection of the azo group to affect the liver and the aromatic amine group (beta-naphthylamine) to affect the urinary bladder is a peculiarity perhaps due to the facts that these are simpler molecules than the polycylic hydrocarbons and the selective action at certain sites may represent the action of metabolites of these substances. The latent period of six to twenty-five years between exposure and the development of bladder tumors necessitates that many physicians re-examine their previous time concepts; it also may well suggest some changes in the legal structures as regards the statute of limitations.

Evidence is gradually accumulating that the release of energy by nuclear fission may constitute a carcinogenic hazard under certain conditions. Glücksmann concludes that from considerations of dosage and general radiosensitivity, four preferential sites of tumor induction or carcinogenesis may be expected after exposure to external radiations:

(a) Skin cancers due to the greater absorption of soft radiations by the skin.
(b) Leukemia because of the great radiosensitivity of the blood-forming system.
(c) Lung cancer after the inhalation of radioactive particles.
(d) Osteosarcoma after the ingestion of radioactive substances.[6]

Three distinct mechanisms by which external radiation could possibly induce tumor formation require careful consideration:

(a) The direct carcinogenic effect with the induction of tumors in the localized normal region.
(b) Co-carcinogenic effect in which radiation combines with other predisposing agents to precipitate carcinogenesis.
(c) The remote effect as a result of single or multiple whole body exposures to radiation inducing a systemic reaction as leukemia or experimental mouse ovarian tumor. It is also conceivable that the remote effect may shorten the latent period of spontaneously arising tumors.

Further confirmation of this potentiality of atomic energy is found in the report of Folley, Borges and Yamawaki, who found a significant increase in the incidence of leukemia in the exposed population of Hiroshima and Nagasaki as compared with the nonexposed populations of the two cities.[5] The observed effect occurred in subjects exposed within 2000 meters from the hypocenter of the atomic bomb explosion. These authors conclude that radiations from the atomic bomb explosions at Hiroshima and Nagasaki are potent leukemogenic agents in man.

The summing up of the reports presented in this paper suggests a significant trend toward increasing utilization of carcinogenic substances with the growth of modern industry and technology. Industry, in addition to asking itself "Is this substance or process essential, effective and economic?" should be prepared to answer the question pertaining to the health of the worker, "Is the substance or process non-toxic and non-carcinogenic?" Failure to evaluate properly the latter

question may well subject the industry to punitive legal action. Sufficient experience with occupational cancer has been accumulated to demonstrate that, given proper conditions and length of exposure to a potent carcinogenic agent, the occurrence of cancer among the exposed persons is only a matter of time.[10] Depending on factors of intensity, dose, and time, the ambivalent properties of carcinogenic substances or electromagnetic energy may produce either degenerating, necrotizing, aplasiogenic changes or hyperplastic, cancerоid, leukemoid, cancerous changes. The occurrence of a wide range of these reactions in a given population constitutes the environmental carcinogen pattern.

The probable industrial utilization of fission by-products and ultimately atomic energy in the near future poses grave questions—unanswerable as yet—over its potential hazards.

It is not within the province of the scientists of the atomic age to venture into the realm of the Law. It may be pertinent at a time when we enter a new era replete with potential issues for which but scant legal precedent can exist to ask ourselves whether the law concerning such issues should grow and develop by accretion of decisions on individual cases or whether society would be better served and protected by legislative formulation of equitable laws founded upon sound scientific understanding of these perplexing questions.

Conclusions

An attempt has been made to present the current opinion of competent medical investigators on the question of trauma as a carcinogenic agent. The common lay belief that simple mechanical injury—as a blow or contusion—as a carcinogenic factor is denied. The capacity of other traumatizing substances or forms of energy to function as carcinogenic agents is documented. Reasonable criteria for establishment of such a case are suggested. A question is asked as to the best and most logical path that the Law and Medicine should follow in coping with probable issues in the foreseeable future.

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There are several lesions occurring in the larynx which may simulate cancer clinically, namely, benign mucus polyps, pachydermia, papilloma, tuberculosis and syphilis.

* * *

To the experienced, a differential diagnosis of cancer of the larynx based on clinical characteristics alone is often inaccurate.

* * *

In doubtful cases of laryngeal cancer an accurate diagnosis can be made only by biopsy.

Lack of immediate facilities or experience for direct laryngoscopy is no excuse for failure to exclude the possibility of cancer by histologic examination.

* * *

In general, it appears that not more than 10 to 15 per cent of thyroid tumors can be greatly helped with radioiodine.

* * *

Cancer of the tongue, which was first a surgical problem and then a radiation problem, is now becoming a surgical problem again.

Artificial Insemination and the Law

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THE INSEMINATION of human beings by artificial means is not new, but it was not until comparatively recent years that the practice became widespread. A good deal has been written on the subject, but most of this is necessarily conjectural. The writers agree on one point, and that is that nobody knows much about the rights and liabilities of the parties involved because the question has seldom come up in the courts. There are a few widely publicized cases, but although certain questions are discussed by way of dicta, the decisions are precedent for only a few questions of law.

Definition

Artificial insemination is the introduction of semen into the female reproductive tract by mechanical means in order to effect pregnancy without sexual intercourse. Where the husband is fertile and the wife is capable of bearing a child in the normal way, but normal intercourse is for some reason impossible, semen of the husband is used for the operation. No special legal problems arise in this situation, which is known as homologous insemination, or AIH. It is heterologous insemination, or AID, the situation where the semen of a third party donor is used, that gives rise to legal complications, and indeed, has the effect of creating entirely new legal concepts.

Annulment Granted Where Child Resulted from AIH

An English court in L. v. L. (1949, 1 A11 E. R. 141; 65 T. L. R. 88) granted an annulment of marriage for failure of consummation after the wife had borne a child by artificial insemination homologous, in an attempt to remove the psychological reasons for her husband's impotence. The court said the stigma of illegitimacy was not what it once was, and it preferred to bastardize the child so conceived rather than uphold the validity of a marriage which it deemed unconsummated. The court was unwilling to consider that a marriage was consummated by anything short of sexual intercourse, even though the wife had by artificial insemination surrendered her reproductive powers to her husband. As precedent for the holding that the decree did not violate public policy, the court cited Dredge v. Dredge (1947, 1 A11 E. R. 29: 63 T. L. R. 113), a case involving a child, conceived before marriage, who had been legitimate for seventeen years until the marriage was decreed a nullity. It has been suggested that the time has come when incapacity and wilful refusal to consummate should be made ground for divorce and not nullity, because the stigma of bastardy is too great. (L. C. B. Gower, commenting on L. v. L. in Modern Law Review (Eng.) 12:384-7, 1949). That is the law in England. The divorce laws of Michigan are much more liberal and the courts should not have to rationalize to attain an equitable result in such a case.

Presumption of Legitimacy

Language in Russell v. Russell (1924 Appeal Cases 687 at p. 721) is frequently quoted in discussions of artificial insemination, but that case is authority only for the fact that in England the rule laid down by Lord Mansfield, that the declarations of a father or mother cannot be admitted to bastardize the issue born after marriage, is still good law. The case involved, not artificial insemination, but birth control, and the court said that the law is not interested in the exact process preceding the institution of pregnancy, providing the husband is the biological father of the child.

Admissibility of Evidence to Rebut the Presumption

Many courts have relaxed the rule of the Russell case and support the proposition that the presumption of legitimacy may be wholly removed by proper and sufficient evidence showing that the husband was impotent; entirely absent so as to have no intercourse or communication of any kind with the mother; entirely absent at the period during which the child must in the course of nature have been begotten; or present only under such circumstances as to afford clear and satisfactory proof that there was no sexual intercourse. (3 R. C. L. 727). There are a few cases in this country holding that evidence that a child born during wedlock is of a different race or color than the mother's husband is admissible for the purpose

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of rebutting the presumption of legitimacy. (31 A. L. R. 1119). In Bullock v. Knox (96 Ala. 195, 11 So. 339) the court declared that a child is a bastard though born or begotten and born during marriage when it is impossible that its mother's husband could have been its father; and that every species of legal evidence tending to this conclusion is admissible on the trial of the issue as to its legitimacy.*

Legitimacy as Viewed by the Court in the New York Case

On the question of legitimacy of a child conceived by AID, the Supreme Court of New York County in Strnad v. Strnad (190 Misc. 786, 78 N. Y. S. 2d 390) undertook to lay down the rule that a child conceived by AID with the consent of the husband was legitimate, stating that logically and realistically the situation is no different than that pertaining in the case of a child born out of wedlock who by law is made legitimate upon the marriage of the interested parties. The court ignored the fact that in the one case the husband is the biological father and in the case of AID he is not, and that this fact alone is the basic reason for the illegitimacy of the child. The Michigan statute M.S.A. 27.3178 (153) legitimizing the child whose parents intermarry was enacted to legitimize the child of the biological father. It does not pertain to intermarriage between a man and a woman who is the mother of an illegitimate child by another man.

The Strnad case was a custody suit involving the right of the husband to visit the child conceived by AID. He was not shown to be an unfit guardian of the child, and it was found that the best interests of the minor child called for visitation by him. The court said that the child had been potentially adopted or semi-adopted by the defendant, and in any event, with particular reference to visitation, he was entitled to the same rights as those acquired by a foster parent who has formally adopted a child, if not the same rights as those to which a natural parent under the circumstances would be entitled.

Is AID Adultery?

As to whether AID constitutes adultery, the Ontario court in Orford v. Orford (49 Ont. L. R. 15, 1921) expressed the opinion by way of dicta that heterologous artificial insemination would be adultery, and defined adultery, under the facts of that case, as the voluntary surrender of the reproductive function of a married woman to one other than her husband. However, the court found that, whatever the wife's physical incapacity for normal intercourse had been at the time of her marriage, the birth of the child resulted from an actual act of adultery. In defining adultery, the court noted that "all the definitions, whatever may be the system of law or whatever the country in which the term calls for definition, use the term 'sexual intercourse' or some synonymous expression to describe one of the necessary ingredients or characteristics of the offense." The judge traced the definition back to Mosaic law, and said that the essence of the offense of adultery consists, not in the moral turpitude of the act of sexual intercourse, but in the voluntary surrender to another person of the reproductive functions or faculties of the guilty person. The court stated the law to be that, no matter how indecent the act, nothing short of sexual intercourse constitutes adultery. Therefore, he reasoned that it is not the moral turpitude that matters but the invasion of the reproductive function; and he added, "If it were necessary to do so I would hold that that (the introduction into her body by unusual means of the seed of a man other than her husband) in itself was sexual intercourse. ***And if such a thing (AID) has never before been declared to be adultery, then on grounds of public policy, the court should now declare it so." Under the reasoning in the Orford case, the marriage of the plaintiff and defendant in L. v. L. would have been declared valid, had the case come before the Ontario court.

The question as to whether or not AID constitutes adultery has not been passed upon by a court of last resort in the United States, but in Hoch v. Hoch (*Chicago Sun,* Feb. 10, 1945), a case before the Circuit Court for Cook County, the husband sued for divorce on the ground of adultery, and the court held that no definition of adultery includes artificial insemination.

Consent

It is the usual thing for the doctor who practices artificial insemination to have the husband and wife sign a written consent to the operation.

*See also Sullivan v. Hugly, 32 Ga. 316; Nolting v. Holt, 113 Kan. 495, 215 Pac. 281; Editorial, J.A.M.A. 112:1832, May 6, 1939.

These consents are witnessed, and there are various suggested forms.†

The suggestions include, among other things, provisions giving the doctor authority to select the donor, and for the destruction of all records pertaining to the donor, and the safeguarding of, or designation of a suitable depository for, the consent itself. It has been suggested also that the parties undertake to save harmless the physician from any claim or action arising out of the operation, and to see to it that the rights of third parties will not be adversely affected by the birth of a child as the result of the insemination.

Effect of Consent on Legitimacy

How far such a consent will protect a child conceived by AID against being declared illegitimate, I do not know. The court said in the Strnad case that the child was legitimate, but the court in that case seemed to be casting around for any possible reason to lift the stigma of illegitimacy from an innocent child. There is no statute in Michigan defining artificial insemination or establishing the status of a child conceived by AID, and there is no Michigan case in point.

If the child is illegitimate, the consent does not ordinarily comply with the legitimizing statute M.S.A. 27.3178 (153), which states that such child shall be considered legitimate for all intents and purposes, provided the parents intermarry or acknowledge such child as the child of the man in an acknowledgment, executed by the father and the mother, if she be competent, and acknowledged in the same manner as required for the execution and acknowledgment of deeds of real estate, and recorded in the office of the judge of probate of the county where either the father or the mother is a resident. In Ghosson v. Estate of Stewart, (319 Mich. 204, 29 N. W. 2d 282), the court held that the statute must be strictly complied with to entitle the child to share in the father's estate.

In any event, the "father" contemplated by the statute is the biological father of the child. The husband in the AID case is obviously not the biological father of the child, and his consent to AID, even one complying with the recording statutes, could not operate as such acknowledgment. Actually, his consent is an acknowledgment that he is not the biological father of the child. Conceivably, only the donor would qualify to act under the statute, and that is a ridiculous proposition, because the whole purpose of AID is to use a donor merely as a means to provide the husband of the woman inseminated with an heir.

We should remember that it is general practice that the doctor who performs the artificial insemination does not deliver the child. The purpose of this is to keep secret the child's origin and to protect the doctor in the case of AID from the onus of having either to betray the patient's confidence or falsify the birth certificate. Under this practice, the foster father is named in the birth certificate as the father of the child, and an acknowledgment by him would not be entitled to record, under the ruling that, where a child is born during wedlock and the birth was certified as legitimate, it would be improper to receive an acknowledgment of paternity under Sec. 27.3178 (153) M.S.A., since the section applies only in cases of illegitimate births. (Op. Atty. Gen. Aug. 29, 1949, No. 1038). Until a child born during wedlock is adjudicated illegitimate, acknowledgment as provided by this section cannot be accepted by the probate court for record. (Op. Atty. Gen. Sept. 16, 1946, No. 0-5050).

It has been suggested that the mother and foster father undertake in writing to see to it that rights of third parties will not be affected adversely by the birth of a child conceived through artificial insemination. As a practical matter, they can have no way of knowing what persons might in future years be affected adversely by the birth of such child, and it does not seem too farfetched to anticipate the death of both parties years before the death of the child, and the impossibility of fulfilling the undertaking by any means other than a public record of the fact that the child was produced by artificial insemination. Then, too, it is possible that the husband was not sterile after all. Would such an undertaking cut the child off from any inheritance whatever in favor of an afterborn child, if a natural afterborn child were held to be one of the class of third parties contemplated by the provision?

Rights of Illegitimate Child

The right of inheritance of an illegitimate child is well defined in Michigan. The illegitimate child

†See Editorial, Medicolegal Aspects of Artificial Insemination, 147 J.A.M.A. 250, Sept. 15, 1951, in which is set forth a form from "Doctor and Patient and the Law," L. J. Regan, St. Louis, C. V. Mosby Company, 1949; also see J.A.M.A. 116:2747, June 21, 1941, Frances I. Seymour, M.D. and Alfred Koerner, M.D.).

is the heir of his mother and shall inherit her estate, in like manner as if born in lawful wedlock, and shall be allowed to claim as representing his mother any part of the estate of any of her kindred, either lineal or collateral. (M.S.A. 27.3178 (151). This right of inheritance is transmitted to the legitimate children of the illegitimate child, and they inherit from the ancestor through the parent. (Goodell v. Yezerski, 170 Mich. 578, 136 N. W. 451).

Should the foster father tire of supporting the child of AID, there is no law in Michigan under which he could be compelled to do so. The statute (M.S.A. 25.462) provides for support of illegitimate children, but acknowledgment of the father that he is the father or other proof that he is the father is necessary to enforce support. Could the donor be compelled under the statute to support the child whose mother he had never seen? Practically, he could not, but only because under ordinary practice he could not be found.

Would the Consent Operate as an Adoption?

Despite the words "potentially adopted or semi-adopted" used by the court in the Strnad case, the consent would not serve in Michigan as an adoption, for adoption proceedings are purely statutory (M.S.A. 27.3178 (541 ff.), and the court has ruled that, in order to accomplish an adoption, there must be substantial compliance with the statute pertaining thereto. (Roberts v. Sutton, 317 Mich. 458, 27 N. W. 2d 54). That case is authority for the rule in Michigan that a contract to adopt might be found where the facts warrant it. But remember that such facts give rise to years of litigation. And in Albring v. Ward (137 Mich. 352, 100 N. W. 609) the court found no such contract to adopt, although an attempt had been made to adopt by invalid proceedings. The contract theory seems to be in conflict with the words of the court in the Strnad case when it talks about a "potentially adopted or semi-adopted" child, for there was nothing suggesting a contract to adopt in the facts of that case.

Rights of Inheritance by Adopted Child

Should the Michigan court follow the Strnad case and find an adoption, the laws of inheritance are clear. The adopted child is the heir at law of the adopting parent or parents the same as though he were in fact the child of such adopting parents. M.S.A. 27.3178 (549). But that child does not inherit from the kindred of the adopting parents. (Van Derlyn v. Mack, 137 Mich. 146, 100 N. W. 278; Moritz v. Callender, 291 Mich. 190, 289 N. W. 126; Moritz v. Horsman, 305 Mich. 627, 9 N. W. 2d 868).

As to the position of the donor in AID, the child would not inherit from him in Michigan unless he acknowledged the child under the statute. M.S.A. 27.3178 (153).

To Protect the Child's Inheritance

The couple contemplating AID should be advised that, while they may wish to create a status for the child exactly as though that child were their own, that is an impractical dream. The child is not their own child, nor can it become as their own even after legislation is passed defining its status. That legislation will be subject to interpretation by the courts, and the courts are not likely to extend the rights of the child conceived by AID beyond the rulings governing inheritance by adopted children. A New York court has aptly stated the principle underlying these rules in In Matter of Hall's Estate (234 App. Div. 151, affirmed 259 N. Y. 637, 182 N. E. 214) thus: "The statute * * * does not * * * permit one to adopt heirs for third persons."

The child's right to inherit might be protected by a will, but it must be remembered that such a will must be carefully drawn with the child properly described. Does "my son, George," in the will of the foster father properly describe the son conceived by AID? I do not believe it does at the present time. When the proper legislation is passed, then that description will serve, but in that event George will inherit as the heir of the foster father. And in order that George may inherit from his paternal grandparents under any laws that may be anticipated, the grandparents are still going to have to make a will.

The Question of Adultery

If AID constitutes adultery, as was stated without reservation in the Orford case, then it would seem impossible that the child produced thereby could be declared legitimate, yet under French law that is exactly what takes place. (Editorial, J.A.M.A. 135:729, Nov. 15, 1947). The editorial quotes R. Savatier, Professor of Law at the Poitiers Faculty. "The woman who consents (to AID) introduces an intruder into the family. This constitutes adultery, which is not absolved by

the courts, even by the consent of the husband. Being similar to adultery it would be grounds for divorce or judicial separation. On the other hand, repudiation of paternity is impossible on the ground of impotency or adultery because the husband is the legitimate father of the child." It is entirely possible that this same line of reasoning might follow legislation legitimizing the child conceived by AID.

If AID is declared to be adultery, unless condoned, the husband would have ground for divorce or legal separation. And if the wife is guilty of adultery, then the donor is guilty as well. (M.S.A. 28.218). The section defines adultery as "the sexual intercourse of two persons, either of whom is married to a third person." But let me note again that the court in Orford v. Orford, when it defined adultery and included AID within its scope, noted particularly that those words were common to all statutes defining the offense.

The Question of Rape

Probably it does not happen too often that a woman is inseminated without her consent. However, it is not difficult to bring such an act within the definition of rape. And if the doctor is guilty of rape, then the husband who aided and abetted the crime would himself be guilty of rape. In People v. Chapman, (62 Mich. 280, 28 N. W. 896) a husband who aided and abetted a rape on his wife for the purpose of securing evidence for a divorce was convicted of rape. And it has been held in People v. Meli (193 N. Y. S. 365), under a statute similar to M.S.A. 28.979, which abolishes the distinction between the accessory and principal, that while a husband cannot personally be guilty of a rape on his wife, if he counsels or aids or abets or assists or forces another to have sexual intercourse with her, or forces her to submit to sexual intercourse with another, he is guilty of rape.

Necessity for Regulation

A survey conducted by the National Research Foundation for Eugenic Alleviation of Sterility (reported in J.A.M.A. 116:2747, June 21, 1941 by Frances I. Seymour, M.D. and Alfred Koerner, M.D.) shows that in 1941 nearly 10,000 women had achieved at least one pregnancy by artificial insemination. In two-thirds of the cases the semen of the woman's husband was used, and donors furnished the rest. Whether we like the procedure or not, something should be done to protect the children, who now may be nullius fillius, so far as the law is concerned. And something should be done to regulate the practice of artificial insemination. When we consider that the successful pregnancies covered by the survey required from one to seventy-two inseminations, and that a comparatively small number of doctors are engaged in the practice, regulation is necessary for the protection of all parties concerned, the doctor, the parents and the child, and the donor and his wife, or the operation should be declared to be a crime.

A report of an unofficial Commission of the Archbishop of Canterbury in 1945 recommended that AID should be made a criminal offense. But it was argued in debate in the House of Lords in 1949 that such legislation would only drive it underground and out of the control of reputable medical practitioners.

Minimum Statutory Provisions

There are certain minimum requirements that any proposed statute should cover. It should provide a form of consent to be signed by the husband and wife, and a penalty for performing the insemination without such consent. The prerequisites for execution of an acknowledgment of paternity under M.S.A. 27.3178 (153) might well apply to such consents, viz., that they be executed and acknowledged in the same manner as required for deeds of real estate. The state department of health, where the birth records of illegitimate children are required to be filed, would be the logical custodian of the records of artificial insemination. (M.S.A. 14.232). However, the provision of M.S.A. 14.236 that copies of illegitimate births shall not be furnished to anyone but the mother of the child or the child except upon order of a court of competent jurisdiction might better apply to the consents in artificial insemination, rather than M.S.A. 14.232, which allows the furnishing of such records to a much larger class of persons, and which prevails over Sec. 14.236 in this respect. (Op. Atty. Gen. Sept. 30, 1947, No. 590). A well-drafted statute, which was proposed in New York but failed of enactment, contained a provision that would preclude a parent from showing in evidence that the child was conceived by artificial insemination. The selection of donors should be regulated with respect to blood typing and examination for certain diseases. Of course, the statute would not be complete with-

out defining the status of the child with respect to the mother and foster father, their duty to support the child, and his right to inherit from them. It should also define the status of the child as regards inheritance from the kindred of the foster father.

Where the Doctor Stands

Not much has been said here about the position of the doctor who performs the insemination. It goes without saying that the husband and wife should always be required to consent in writing to AIH or AID, although if AID should ever be declared to be against public policy, then no form of consent whatever would be of any value. Frances I. Seymour, M.D. and Alfred Koerner, M.D. suggest that finger prints of both husband and wife be placed on the margin of the consent as a precaution against fraud by a wife who is unknown to the doctor and who, because of her husband's objection to the insemination, might bring in some sterile friend for the examination as to sterility and to sign the consent. (J.A.M.A. 107: 1531, Nov. 7, 1936).

The care and skill required are the care and skill employed by an ordinarily careful and skillful practitioner of artificial insemination in the exercise of his best judgment under like circumstances in the same or similar communities. A report of the Bureau of Legal Medicine and Legislation of the American Medical Association (J.A.M.A. 147:250, Sept. 15, 1951) calls attention to the fact that the physician assumes certain risks of unsatisfactory results due to the unfitness of the donor in AID, but does not attempt to say how far a woman and her husband may relieve him of that responsibility. And no more can anyone else. Under the general rule as to malpractice, the physician must use his best judgment. Since the amount of care varies with the circumstances of each case, it would seem that the nature of the physician's undertaking would require care in a degree never before assumed by the medical profession. In AID the physician acts as the agent to bring into being a life outside the marriage relation. Even ignoring the moral aspects of the case, that is new and outside the scope of anything the physician has ever undertaken before.

Moral Considerations

The moral side of the question is not within the purview of this paper. But I might note briefly that I have not found any statement by the Jewish or Protestant churches, other than the Church of England, touching on this question. The report of the unofficial Commission of the Archbishop of Canterbury in 1945 expressed no objection to artificial insemination homologous, but declared artificial insemination heterologous to be adultery. (Modern Law Rev. (Eng.) 12: 384-7). The Rev. Dr. F. J. Connell of Catholic University of America has stated that the procedure in heterologous insemination violates the social purpose of matrimony "because the child so conceived and born springs from parents not married to each other." (*New York Times,* March 12, 1947, p. 20, col. 2). But it would seem that even homologous artificial insemination might violate another precept of Catholic teaching, depending upon the method used to collect the spermatozoa. The Church would condone AIH only when the sperm is collected by aspirating the material through testicular punctures. This method has been reported (19 Bull. N. Y. Academy of Medicine, 573-82, 1943) as being largely unsuccessful, though Doctors Seymour and Koerner, as a matter of routine practice, use material collected by testicular puncture in examining the husband for sterility before performing an artificial insemination. (J.A.M.A. 107:1531, Nov. 7, 1936).

Therapeutic Value

The advocates of artificial insemination argue that the therapeutic value of bringing a child into the childless home more than compensates for any risks involved. A survey of the sociologic and psychologic effects of artificial insemination with donor semen (reported by H. L. Lamson, W. J. Pinard and S. R. Meaker in J.A.M.A. 145:1062, April 7, 1951) showed that unhappiness in marriage probably results more from not wanting children than from not having them. They also pointed out that some men were psychologically unable to welcome the child of an unknown donor into the home, even though they might wish to do so. The authors emphasized the need for the greatest care in determining whether or not to perform the operation because of the psychological problem, and warned against the danger in assembly line manipulation of life.

Conclusion

In conclusion, it may be said that the physician who performs the insemination, the husband and

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The Struggle of the Patient Against the Doctor

By Gregory Zilboorg, M.D.
New York, New York

WHENEVER a group of men foregather officially to pay tribute to a member of their profession, it is expected that they will tell him to his face and to themselves only those things which are good and pleasant. They would certainly avoid telling him what they do not like about him, or what they consider his errors or defects. On such occasions, men are in a happy, laudatory mood, and that mood would certainly be jarred if they permitted themselves to think of unpleasant things and suddenly tell what is wrong with the man to whom they want to pay public tribute by a public display of affection and loyalty.

Please do not be anxious and do not anticipate that I came here to give voice to any criticism. First of all, I don't think I was "imported" from another state for the purpose of playing the role of the devil's advocate, or of the devil himself, in order to tell Dr. Leo Bartemeier to his face a few unpleasant things. There are so many unpleasant things in this world, and so many defects of character and errors of judgment, that there is enough to go around and for every one of us to get his share willingly or unwillingly, wittingly or unwittingly. There is enough for every one of us here. As a matter of fact, I think it is dull and trite for any group of people, especially doctors, to repeat the gentle acrimonies and the bitter kindnesses which we tell or whisper about each other in private, or in semi-private. And I did not come all the way from New York to be deliberately dull.

On the other hand, I just won't fall in with a singular custom and engage in an outpour of superlatives about Leo Bartemeier. For, as I see it, we are paying tribute tonight to a man who achieved some rather unique professional recognitions and distinctions, and we envy him, and we wish—some of us at least—it were our lucky lot to have arrived at such level of distinction at such an age. What is more, in so far as we consider him one of us, that is to say our very own, we certainly wish to be a part of this brilliant professional career, and we get together and as one we rejoice in what Leo Bartemeier has achieved as a leader, as a friend, as a doctor, as a professional man, as a human being. All of us here in this room tonight are, so to speak, one big Leo Bartemeier, as if we could or should be much bigger, and we rejoice in this communal identification with him whom we are dining and wining and vociferously lulling into the false belief that he achieved almost everything a man, a doctor, could achieve. And we too have achieved it all through him. We rejoice that, although this is not exactly the end of a perfect day, it is at any rate a wonderful occasion to eat ourselves, drink ourselves, and talk ourselves into the belief that everything is wonderful in this wonderful world, in the wonderful medical profession, in the wonderful medical profession of the State of Michigan, and in the wonderful life of the wonderful Dr. Leo H. Bartemeier.

As I told you, I did not come here to disabuse you of your faith in or delusions about Leo Bartemeier. I could not do this for many reasons, the major one of which being that I have my own faith in and delusions about Leo Bartemeier. And what can be a greater faith, a more human and enjoyable delusion, than the knowledge and experience of that humanness and that charm and that sense of loyalty which is associated with the name of the man whom you are honoring tonight, and of whom I have the honor and the humble pride of being an almost life-long friend? However, Leo Bartemeier would not want me, nor would I be tempted, to sell my conscience for the stately meal of which we have just partaken and therefore forego the discomfort of telling you some of the difficulties under which Leo Bartemeier works. These difficulties are also mine, I must confess, and they are also the difficulties of many of those present here.

The first difficulty is this: Leo Bartemeier is a psychiatrist. Not that psychiatry is difficult, but it is difficult to be a psychiatrist; psychiatry is difficult enough for the many who are not psychiatrists, but it is most difficult for the psychiatrist himself. Why? How? To answer these queries means to list all the difficulties involved in being a psychiatrist, and I shall proceed to describe some of the issues involved without systematically numbering or labeling them.

As a doctor the psychiatrist deals with patients, which means with people who are ill, and his job is to treat them, which means to minister to their health. Please note that I did not use the word

Address delivered before the Michigan Society of Neurology and Psychiatry, Detroit, March 12, 1952.

"cure." Most of you know how dangerous and misleading a word it is. Do we really cure our patients? Does any of us, any of them? Would it not be better to return to the older Hippocratic tradition which was still fully alive even seventy-five years ago? According to this tradition, the physician does no more than help the *vis medicatrix naturae,* the healing force of nature, to do its job. The word physician originally meant one who *took care* of patients so that nature could cure them. The direct and almost the last exponent of this point of view was Oliver Wendell Holmes, who always reminded his students and young physicians of his friend and teacher Jackson, who emphasized that *to cure* a patient means *to care* for him. In this respect there is little difference between the psychiatrist on the one hand, and the internist or surgeon or any other medical specialist on the other. But here the absence of difference ends. From here on there is confusion even, or particularly, in our day when psychiatry is so popular, so well advertised, so generally admired and so just as generally but perhaps less publicly disliked.

I mentioned Oliver Wendell Holmes. Let us see what Holmes thought of the need to be treated.

"In the first place," said Holmes, advising young practitioners, "the persons who seek the aid of the physician are very honest and sincere in their wish to get rid of their complaints, and, generally speaking, to live as long as they can. However attractively the future is painted to them, they are attached to the planet with which they are already acquainted. They are addicted to the daily use of this empirical and unchemical mixture which we call air, and would hold on to it as a tippler does to his alcoholic drinks. There is nothing men will not do, there is nothing they have not done, to recover their health and save their lives. They have submitted to be half-drowned in water, and half-choked with gases, to be buried up to their chins in earth, to be seared with hot irons like galley-slaves, to be crimped with knives, like cod-fish, to have needles thrust into their flesh, and bonfires kindled on their skin, to swallow all sorts of abominations, and to pay for all this, as if to be singed and scalded were a costly privilege, as if blisters were a blessing, and leeches were a luxury. What more can be asked to prove their honesty and sincerity?"[1]

True as these words about patients are, they sound a bit suspicious to the modern ear. Holmes seems to protest too much, as if he wished to disabuse young physicians of their suspicions that some patients at least are neither sincere nor honest about their complaints. We might recall in this connection that Holmes spoke with questionable charity, considerable haughtiness, and acidulous smugness of certain ladies (whom we would call neurotic today) who would feel sick if they were well, and who felt well only when they were sick and had their great quantities of pills within and around them. Intuitively, Holmes must have sensed something about these ladies with which we are quite familiar in modern psychopathology.

There is an essential difference between the "sincere and honest" complaint of the average so-called organic patient and the psychological patient. That essential difference has many aspects. One of them, for instance, is that the psychological patient will "honestly and sincerely" not believe that he is psychologically compromised until forced to by circumstances, whereas he will readily accept any diagnosis from appendicitis (which is after all easily demonstrable) to virus x (which one cannot demonstrate to him at all). I don't want to dwell upon this very familiar venture of psychological illness, because I wish to try to bring to light before you a less generally familiar feature of psychological pathology with which I believe every physician should be familiar, and which even some efficient psychiatrists have on occasion considerable difficulty in discerning.

A clinical illustration.—A gentleman of about forty years of age, a pleasant and cultivated and successful person. He is all that falls under the heading of "a well fed, white, married American man" who looks well, eats well, and has a neurosis —never mind which—and who has been in psychoanalytic treatment for some time. The treatment was progressing slowly, but well. At the exact moment which I wish to relate to you, he was rather cheerful and not too much concerned even though he developed rather suddenly a pain in his right shoulder and arm. He did not think of consulting his family doctor about it, nor did he ask me what to do about it. Instead, he merely reported with considerable definiteness that the pain

[1]Oliver Wendell Holmes, "The Young Practitioner." (A Valedictory Address delivered to the Graduating Class of the Bellevue Hospital College, March 2, 1871.) In: *Medical Essays* 1842-1882, p. 378. Boston: Houghton, Mifflin and Company, 1889.

was a result of his having had a very mild case of poliomyelitis some five years previously which had left no sequelae. At the time of the alleged attack of poliomyelitis he did have pain in his right shoulder. Now, it was "that pain." No, of course, he did not think he had polio again; it was merely a result of a weakening of his arm muscles. No, he had not sprained or strained his arm recently. His wife had advised him to use her masseuse to give the weakened muscles some exercise, and he now had massage every day and also used heat and epsom salt baths. The latter remedy had been prescribed by the masseuse. As he was telling me all this, the patient was "working" his arm and shoulder rather vigorously as if to demonstrate where and how it hurt, and while he was doing this his facial expression betrayed no physical discomfort.

There was little doubt in my mind as to the paradoxical nature of this patient's muscular symptoms. It mattered little whether it was a "myositis of unknown origin" or an undetermined complaint of undetermined physical origin. It certainly was not "nothing." Nor was it one of those hyphenated nothings which some are prone glibly to call psychosomatic while remaining unclear as to the somatic pathology of the psyche or the psychic pathology of the soma. Suffice it to say that when a patient says he has a pain it *is* a pain, whether it is "purely" psychic, or "purely" somatic, or a mongrel of the two. There is no "imaginary" pain except in the imagination of the incredulous physician or the unenlightened skeptic. A pain is a pain —and when a patient has it, he does not like it.

The difficulty begins with the very first attempt to relieve the patient of the pain which he asks us to remove. The most flagrant example of such a difficulty is the well-known compensation case who "refuses" to get well no matter what you do. As a matter of fact, the more you do for such a case the more the person involved is apt to become desperate—the doctor because of his failure despite everything he does, the patient because of not getting well or of getting more pain or new symptoms. The platitudinous explanation which is usually given in such cases really does not hold much water. For to say that such a patient prefers to draw the pittance offered him by compensation insurance and live in undignified misery is to say something that does not sound quite right, no matter how often such an explanation is offered or even generally accepted. No one prefers to be miserable in exchange for twenty dollars a week, with a pain or insomnia constantly poisoning his life, and his wife and several children in need and desperation. There must be, there is something about such people which makes them behave the way they do. No one really, consciously, rationally chooses invalidic dependence combined with desperation. The ready-made "logical" and pseudo-rational explanations which used to be given for such cases have lost their medico-psychological meaning.

During the last twenty-five years or so more and more members of the medical profession have come to understand the true psychology of why people with symptoms of purely psychological or mixed origin seem not to respond to usual treatment; more than that, at times they seem to get worse the more we do for them by way of medicamentous or persuasive therapy—that is to say, they show what became known over thirty years ago among psychoanalysts as "the negative therapeutic reaction." To put it in our everyday idiom: some of our patients develop new symptoms, or the old ones become exacerbated, seemingly as a direct result of our therapeutic efforts. At times the physical aspects of the clinical picture may even disappear; but the patient, instead of being relieved and happy, merely says that he is glad his headache is gone, or his twitching has disappeared. However, he does not appear to be too happy, he even seems distressed or restless, or listless and depressed: as if a depression or an anxiety had taken the place of his headache or his muscle twitching. What is it that happens to these patients? Let us leave the strict meaning of the term "negative therapeutic reaction" alone and return to our patient with the shoulder pain. For after all, patients are our very best source of information as long as we keep our wits and avoid ready-made, facile, logical constructions.

You will recall that the gentleman with the shoulder pain was under treatment. He had a neurosis, but not an incapacitating one; he continued to function socially quite well, and he also did quite well in business. His trouble was in his marital life, and in his tendency to drink more than was good for him.

At the time he was giving me so many indefinite details about his shoulder pains, I told him that of course I did not know what his shoulder condition

was any more than did his wife's masseuse (Could a psychiatrist be medically more modest?). But I was somewhat uncertain and went over with him the history of his polio. It turned out to be a rather vague history. The temperature never rose above 101°F. The illness lasted only a few days. Three doctors were consulted in succession; one said it was a "muscle sprain;" another said it "might be bursitis"; the third thought it might be a "mild case of polio." The patient settled for polio and recovered uneventfully. At the time the patient was going through a period of particularly acute friction in his home life; he later divorced his first wife.

I inquired as to the exact time the recent shoulder trouble had begun, and when I had received a fairly accurate answer I pointed out to the patient that the attack of pain in the shoulder coincided, more than by mere coincidence it seemed, with a severe quarrel with his present wife during which she had thrown a glass at him and he had slapped her with considerable force. Yes, the patient is a right hander; he used the right hand to slap with, and consequently the right shoulder to swing with.

I shall omit the many details that led almost inescapably to the conclusion that the pain in the shoulder was intimately connected with the blow he had dealt his wife. He was ashamed of his propensity to use physical force (only against his wife), and he was quite irritable when even a faint allusion was first made that the pain in his shoulder might be of psychological origin.

Please note that the patient was irritable. It was at once distasteful to him even to imagine that the shoulder trouble was not a direct successor to his alleged polio of a few years before. As you see, even patients who are willingly undergoing psychological treatment dislike the idea of the psychological origin of certain symptoms. This patient is not an exception. It is here that we find the root of the major difficulty with and in psychiatry, and of being a psychiatrist. In psychiatry the patient always fights the doctor. Some shadowy reflection of this propensity in patients is found even in surgery. Don't we tie our patients to the operating table even after they are fully under anesthesia?—patients might try to struggle and to escape at most inappropriate moments. However, in psychiatry patients are always conscious, and they fight quite consciously but with their unconscious of which they are not aware.

What are they fighting for? What makes them struggle so hard seemingly against their own interest? It would be easy of course to explain their struggle in terms of the patient's so-called need for punishment, by the patient's self-punishing drives. Such an explanation, correct as it is, is yet insufficient. Why that need for constant self-punishment, and whence that fight against absolution, so to speak? Modern psychopathology is forever indebted to Freud for helping us to shed light on this paradoxical problem and offering an answer to the vexing question. He pointed out that almost every psychological symptom, particularly what used to be called the conversion symptom, is characterized by the following paradox: on one hand the symptom is a punishment for a forbidden (unconscious) wish, and on the other hand it is a gratification of the forbidden (unconscious) wish. My patient seems to have punished himself for having hit his wife. This was true, but in part only. Behind this apparent or suggestive self-punishment (it turned out) lurked also another unconscious trend: the patient had wanted to hit his wife, or any other woman who was close to him from his mother on, since his very childhood, because he thought his mother did not love him. He also felt guilty for wanting to hit (hitting) the woman he loved, and as soon as he developed the self-punitive symptom, the woman, in this case his wife's masseuse, took care of him, cuddled him as it were, assured him that what he needed was massage and not a scolding, an epsom salt bath instead of a punch in the nose, heat, warmth, instead of a cold shoulder. In other words, there was a real psychological, emotional gain in this symptom. All this was unconscious of course, and because of this all the more potent and untractable. As I have said, we owe to Freud this discovery—that the psycho-biological processes which produce a neurotic symptom arrange themselves in a sort of equilibrium in which the very symptom itself conceals a secret but genuine gratification.

Under these circumstances, there is a far cry between the "sincere and honest patient" visualized by Oliver Wendell Holmes and the psychological patient who, even when he comes to us, has an ax to grind, so to speak. He is of course consciously eager to get rid of the incapacitating symptoms, but unconsciously he is unwilling to give up that paradoxical equilibrium, that psycho-biological even though pathological gain which is bound to be lost if and when the symptom is gone. Therefore he

must "fight" the doctor, i.e. the psychiatrist, and he does fight him either by becoming unable to give up his symptom, or by developing new symptoms in case the old one is forcibly removed by such means as suggestion or medication.

It always comes to pass that our patients, even when they like us and admire us, fight us; they are unwilling to settle for only the minor half of the bargain, which is the mere disappearance of the discomfort. What is the disappearance of a symptom to them, if the unconscious gratification which goes with the symptom is no longer furnished? The ultimate goal of the psychiatrist is not to provide a substitute for the unconscious (infantile) gratification which must be surrendered, but to provide the patient with the capacity of giving that up too. In other words, while in organic medicine the avowed and actual goal of therapy is to relieve the patient from trouble without any sacrifice at all to the patient, save perhaps a monetary one (exceptions are of course noted and taken into consideration), in psychological medicine the patient is always called upon to make a substantial sacrifice, and not only of money, and no exceptions are to be found to this rule. The psychological patient must sacrifice that which is secretly so dear to him and psycho-biologically so much a part of him.

This is the secret of the great general opposition to psychiatry, for the public and the medical profession as a whole unconsciously identify themselves with the unconscious of the patient. Moreover, each patient, as we psychiatrists so well know, unconsciously expects that the psychiatrist will give him license for the free practice of the infantilism to which he is addicted through his symptom—I speak of the patient, not the psychiatrist.

This is our difficulty: this is Leo Bartemeier's difficulty. And the measure of the man is the moral courage and the spiritual sinew with which he meets this difficulty. It is given to few of us to meet it fully and without many mishaps. That we pay tribute tonight to one of these few is a sign of our own professional and human aspirations.

OPINION EVIDENCE FROM MEDICAL EXPERTS

(Continued from Page 401)

New Legislative Proposal May Invade Privacy

In giving decision, the Court said, at page 273, "It is unnecessary to determine at this time whether the examination proposed in this statute is an invasion of the employe's right of privacy." The requirement of House Bill No. 90, that the Court's experts shall be permitted access to the persons for the purpose of inspection and examination may conceivably meet the scrutiny of the Supreme Court, if the bill is enacted into law.

Lawyer-Doctor Co-operation May Stem Legislative Reform

Necessity for legislative reform may be manifest. Without this, however, it is still possible for the bench and bar, in co-operation with doctors, to exercise stricter enforcement of rules of evidence for the guidance of the expert, and to acquaint him more fully with the wisdom of these rules of evidence. Conferences with medical experts before the lawyer seeks to question them on the witness stand will pave the way for a more consecutive and detailed presentation of expert opinion evidence.

Many local bar associations are conducting joint meetings with doctors to improve the knowledge of lawyers about legal medicine, and doctors frequently are invited to address groups of lawyers.

It is just as important for doctors to know the legal rules which guide adversary litigation in actions for death and bodily injury.

As members of two great professions, all must recognize that the field of expert opinion evidence offers a challenge to the best inspiration and effort of doctor and lawyer, alike.

The Psychosurgery Program of the Wayne County General Hospital

By John A. Belisle, M.D., Rudolf Leiser, M.D., and H. Harvey Gass, M.D.,

Eloise, Michigan

IN AUGUST, 1950, a psychosurgical program was started at Wayne County General Hospital. The initial objectives of this program were two-fold being, first, to benefit the clinical condition of suitable cases by this form of treatment in so far as possible, and second, to evaluate the usefulness of approved psychosurgical procedures. In the conduct of this program, it was at all times recognized and gravely borne in mind that mutilating procedures resulting in irreversible personality changes were employed.

Tending to counterbalance this very serious consideration was the commonly known fact that the psychotic patient who had failed to benefit by treatment or to improve after one year's hospitalization was faced with a nearly hopeless prognosis. His chances of ever returning thereafter to the community dwindled nearly to the vanishing point. What is worse, many of these patients faced years of mental suffering as a result of their psychosis in the form of extreme agitation, depression, and anxiety. Many remained chronically disturbed, self-mutilative, and assaultive to the point where they had to be constantly restrained, or secluded, or drugged to prevent their injuring themselves or those about them.

Because of the grave and damaging nature of the procedures involved, we felt it imperative to avoid its misuse. We conceived as misuse the performance of psychosurgery on any patient where there remained any reasonable chance of remission by any other means at our disposal or by spontaneous remission. We also considered as misuse the performance of psychosurgery on any patient whose psychiatric condition was such that no material benefit could be expected. On the other hand, it was our opinion that radical measures should be considered in those mental malignancies wherein the patient faced a lifetime of hospitalization, during which his own internal suffering was profound, or in which his behavior made him a constant and chronic danger to himself and others.

In order to prevent as far as humanly possible any misuse of psychosurgery, certain very rigid criteria for selection of cases were adopted and strictly adhered to. It was decided that, in order to be considered for psychosurgery, a patient must have been chronically ill for at least three years and institutionalized at least one year. No patient suffering from a disease prone to spontaneous remission was to be considered. The patient must have been refractory to a full course of electroshock treatment and/or insulin treatment. If a patient met these qualifications for operation, and if his psychiatrist thought surgery might be of benefit, the patient's case was presented before a board consisting of four psychiatrists and a neurosurgeon. If a majority of this board believed the patient suitable, he was moved to the treatment ward for a month's close observation. At the end of this time, the case was again reviewed by the board. Any demonstration of improvement under the maximum care of the active treatment ward tended to discourage the use of surgery. Final decision for surgery could be made only by a four-fifths affirmative vote of the board.

In our opinion, the maintenance of these rigid criteria for selection, coupled with careful consideration by a board of psychiatrists prior to operation, prevented as effectively as was possible the inclusion of any patients with any foreseeable hope of recovery or material improvement, by any other means. The other aspect of selection, namely, the task of eliminating those patients who would probably not be benefited by the operation, and the obtaining and selecting of those patients wherein the most benefit could be anticipated was more difficult. It was our belief that before psychosurgery should be decided upon, the examining board should, in so far as possible, determine that at least one of the three following objectives might reasonably be expected to be accomplished by the operation, namely, (1) improvement of the patient's illness and/or symptoms, (2) the return of the patient to home or gainful employment or, (3) the amelioration or elimination of chronically disturbed behavior which was of such a nature as to constitute a serious threat to the well-being of the patient or those about him.

From the Department of Psychiatry (Rudolf Leiser, M.D., Director) and the Department of Surgery (Merle M. Musselman, M.D., Director), Wayne County General Hospital, Eloise, Michigan.

According to the literature, prefrontal lobotomy is a form of symptomatic treatment that has been found particularly valuable in the removal or relief of such symptoms as persistent anxiety, groundless fears of the future, suicidal tendencies, self-mutilation, destructiveness, and persistent depression. Freeman and Watts have declared that success with psychosurgery can be anticipated in proportion to the amount of emotional tension present. Accordingly, we endeavored to select patients for operation who displayed a maximum degree of one or more of the preceding symptoms. We hoped, particularly to lay stress on the amount of emotional tension present. Conversely, we hoped to avoid, as far as possible, selecting cases who were deteriorated to the point of vegetative existence. In practice, the selection of patients manifesting a great deal of anxiety and emotional tension was much more difficult than we had anticipated. The existence of overtly disturbed behavior in the form of self-destructiveness, assaultiveness, or any of its other manifestations was much easier for a psychiatrist responsible for the care of several hundred chronically psychotic individuals to detect. As a result, the majority of cases brought forward for consideration by the examining board were intensely disturbed individuals, who, for the most part, were nearly totally inaccessible. The task of determining the part played by anxiety and emotional tension in the disturbed behavior of such patients was found to be extremely difficult. We believe that many cases marked by extreme inner suffering, anxiety, and depression have been missed and that too many disturbed but deteriorated patients were included. Undeniably, much is left to be desired in this method of selection but that is a question beyond the scope of this report.

By the end of January, 1952, thirty-two patients had been operated on. All operations were performed by one of us (H.H.G.). All of the patients operated upon were diagnosed as Schizophrenia. The average length of hospitalization prior to operation was six years and twenty-seven days. We classified our results into three groups (1) slightly improved, (2) moderately improved, and (3) markedly improved. Three patients died as a direct or indirect result of the operation. All these deaths occurred early in the program and in the light of our present experience are now thought to have been preventable or avoidable. Two of them were due to errors in selection and management. The first mortality occurred in a middle-aged, extremely disturbed, chronic schizophrenic who had been in the hospital for nine years and nine months prior to operation. She was totally unmanageable and a very severe feeding problem. In the course of her illness, she had become extremely emaciated and debilitated. She weighed seventy pounds at the time of surgery. Operation was looked upon as a life-saving measure. In restrospect, preoperative preparations could have been considerably improved, a modified surgical procedure done, or the patient not selected at all. A second patient survived the operation but, through a breach in postoperative management, was allowed to pick at her operative wound. She developed a postoperative wound infection which led to osteomyelitis of the skull and she died seven and one-half months later of meningitis and brain abscess. The third case was a simple operative death, the patient expiring of massive cerebral hemorrhage postoperatively. In this case, a modification of technique had been attempted, using small trephine holes which, it was found, did not allow adequate visualization.

Of the twenty-nine remaining patients, none are worse postoperatively in any way that can be determined by ordinary clinical observation. None are unchanged. Six patients fall into the first classification of slightly improved. All of these patients are chronic, severe schizophrenics who presented very serious problems in management. Postoperatively, none of them shows any change in mental content and all that can be said is that, in general, they are somewhat less disturbed, destructive, and assaultive than they were prior to operation. Outbursts are less frequent and less intense but they still occur and these patients fall short of even good ward adjustment. Fourteen patients have been classified as moderately improved. These patients uniformly show a very definite improvement or complete relief of such symptoms or behavior as extreme agitation, assaultiveness, and self-mutilativeness which primarily motivated the performance of psychosurgery. In that limited sense, the operation on these cases would be considered a complete success. The basic psychotic process in these cases has not been touched, however. Hallucinations and delusions remain unaltered, although much less in evidence. None of these patients could get along outside of an institution unless they could receive constant supervision. In this group, some of the effects of the surgery itself are manifest. Nearly all of these patients have voracious appetites and

some become very obese unless placed on rigid diets. A few of them are rather silly and prone to inappropriate giggling or laughter. Euphoria has not been noted. More characteristic is a peculiar blandness or shallowness of affect—not a typical schizophrenic flatness of affect but more the picture seen in arrested cases of paresis. Yet these patients do not show the mental deterioration seen in paresis. As a group these patients show a very curious "sameness"—a failure to stand out as individual personalities. They show a pronounced lack of initiative in everything and seem unconcerned about the future.

Case 1.—Emma D—provides a good example of this group of patients. This twenty-six-year-old white woman had been mentally ill for some time before admission. After loudly warning the customers in her husband's restaurant not to eat there because he was full of syphilis, she was spirited to the hospital on July 8, 1946. She was very delusional and was experiencing auditory hallucinations. A diagnosis of Schizophrenia, Paranoid and Catatonic types, was made. Electric shock therapy was given but resulted in only slight temporary improvement. She became a chronically disturbed, noisy, destructive patient who attacked everyone near her. She tore her clothing to shreds with her teeth and was nearly always naked.

Following operation, Emma's behavior showed a profound change. She now requires neither sedation nor restraint. She is up and about an open dormitory and she keeps her clothes on. She now takes some pride in her appearance and uses make-up fairly well. She is generally pleasant in a passive way. She eats a good deal and has become moderately obese. She still hallucinates very actively and sometimes shakes her fists at the voices and once in a while will shout angrily at them but she never attempts to hurt anyone. Her affect is bland and shallow. She takes little interest in her surroundings and contentedly sits talking softly to herself.

Lastly, we have classified as markedly improved nine cases out of the thirty-two reported. This group is not as homogenous as the preceding one. Five of these patients are still in the hospital but awaiting disposition. Two of them are still psychotic upon close interviewing, but they are overtly well enough behaved for plans to place them in family care as soon as proper arrangements can be made. Three of the patients are still in the hospital but are not overtly psychotic and should be parolable soon under proper supervision. Four of the patients are at home at the present time. No attempt will be made to generalize about this small group of patients. Instead, we will review very briefly a sampling of these cases.

Case 3.—Myrtle M was admitted to the hospital in 1947. Present illness appeared to develop following the birth of a stillborn child in 1946. After this, the patient was observed to be rambling and incoherent in her speech. She began to hear voices which called her dirty names. Following admission, the patient was so unco-operative that no formal mental examination could be performed. A diagnosis of Schizophrenia, Catatonic type, was made. Electroshock treatments were given with very minimal improvement. The patient was usually in restraint and was very self-abusive. She was loud, obscene, and destructive, constantly tearing off her clothing. Operation was performed four years and three months after hospitalization. One week later, she was noted by the nurses to be "co-operative and easy to handle." Soon she was noted to be "very neat in her dress, co-operative, and follows orders. She is eating well and her table manners are good. She is happy most of the time and laughing to herself. So far she has done very little work on the ward." For some time, however, she was given over to exposing herself, masturbating rather openly, and to making rather indiscriminate sexual advances to people of either sex. These things cleared up rather rapidly, however. In recent months, the patient has remained neat and tidy, generally pleasant and co-operative, and sociable with others. Her general mood is rather lackadaisical and cheerful although she remains rather labile. She expresses a definite desire to leave the hospital but displays little initiative in bringing about this end. The psychiatric staff feels she could make a good adjustment on the outside.

Case 2.—Yvonne K: This patient is an attractive young woman who began to develop mental symptoms following a divorce in 1946. She became seclusive, suffered from insomnia, and began drinking rather heavily. She became argumentative and threatening in her behavior. She finally became violent and destroyed most of the furnishings in her sister's home. Following this, she was hospitalized here. Examination revealed her to be resistive, negativistic, and periodically combative. Her speech was careless and irrelevant. A diagnosis of Schizophrenia, Mixed Catatonic and Paranoid types, was made. Shock treatments resulted in only temporary improvement. She remained very uncooperative, irritable, and assaultive. She constantly attacked and hurt other patients. Following operation, the patient showed dramatic improvement. She was soon able to be up and about the open ward, out of restraint, and no longer attacked other patients or ward personnel. She became very pleasant and co-operative, spoke very freely with other patients, and became very popular with them. She was prone to giggling rather inappropriately at times. She was occasionally irritable with other patients and would assail them verbally but not physically. Seven months after operation, the patient left the hospital on convalescent leave. She obtained a job and has been steadily employed ever since. Her work adjustment appears to be totally satisfactory. She has resided with a sister who complains that the patient is somewhat careless about the home, leaves her clothing scattered all around, and shows little responsibility in doing her share of the household duties. Her social life, however, appears to be normal and she

has two suitors at present. This patient's adjustment seems to be excellent and at least as good as it was prior to her present illness.

Case 4.—Irene D: History information on this patient is very limited. When she was nineteen years of age, she married a man of thirty-five. One child was born of this union. Following its birth, patient became briefly psychotic but cleared up within a short period of time. Her husband left her and they were subsequently divorced. When she was twenty-three years old, she remarried. Following the birth of a second child, the patient again became acutely psychotic and she was hospitalized. Mental examination on admission in 1948 found her to be nearly completely mute and very uncooperative. She refused to talk, refused to eat, and ground her teeth continuously. Diagnosis of Catatonic Schizophrenia was made. The patient was started on sinusoidal shock therapy and showed a remarkable improvement but relapsed very promptly. Repeatedly, she was given electroshock therapy with temporary improvement but in every instance lapsed back rapidly into a similar condition. Patient became and remained an almost indescribable problem in management. She remained in a mute inaccessible state in which she absolutely refused to eat and in which she resisted tube feedings very actively. Following operation, the patient showed dramatic improvement. She ceased to be a feeding problem at all and rapidly began to gain weight. She became pleasant and co-operative and expressed no psychotic ideas. Two months after operation, the patient went home on visit. She maintained a relatively good adjustment at home for a number of months. Then her husband brought back the two children to be cared for by the patient. The patient displayed rather promptly an incapacity to assume the extremely heavy responsibilities of caring for two small children. Her youngest child had become a feeding problem and in her attempt to manage this, the patient frequently became short tempered and often struck the child. She had to be returned to the hospital for the protection of the children. Subsequently, arrangements were made for the patient to reside in California with her parents. Not having the responsibility of caring for her young children, the patient made an adequate adjustment which has continued to the present date.

Case 5.—Matilda C: This patient was born in Italy in 1897 and immigrated to this country in 1938. In 1940, the patient's seventeen-year-old son was drowned at a lake. Following this, the patient became extremely depressed and withdrawn. She cried continuously and refused to eat or drink for a long period. She lost a great deal of weight and began to experience hallucinations and developed delusions of persecution. She was hospitalized here in 1942. A diagnosis of Schizophrenia, Paranoid type, was made. During her hospital stay, the patient was at all times very paranoid and at the same time tended to be quite depressed and agitated. She was a severe feeding problem and she constantly walked up and down the ward, wringing her hands and speaking unintelligibly in Italian. Two courses of sinusoidal shock therapy were given her with no more than temporary superficial improvement. After seven years and nine months hospitalization, lobotomy was performed on the patient. Immediately following surgery, the patient seemed quite flat and sat about the ward in a very inactive fashion. Communication with her has at all times been impossible because of the language barrier. It was gradually noted, however, that she seemed to be taking more interest in things about her and she began to show manifest pleasure in her daughter's visits to her. The daughter seemed very enthused about her condition and reported to us that she could see nothing wrong with the patient. Postoperative course was, however, marked by the occurrence of two grand mal convulsions while the patient was still in the hospital. These were controlled by dilantin therapy. Four and one-half months after operation, she was given a convalescent leave and has been out of the hospital ever since. Her family is very enthusiastic about her condition, the daughter being concerned only with one thing, that is, the fact that this patient who had been a very emaciated individual has gained over a hundred pounds and is experiencing some difficulty getting around. Before her psychosis, this patient had apparently been a very serious, compulsive individual who seldom did much talking. She is now described as being easy going, over talkative, and somewhat overly jovial. According to her daughter, however, she is in good contact with reality, has no trouble making change, and does not appear to show any mental deterioration.

Surgical Technique

Modern psychosurgical procedures have as their common surgical aim the interruption of nervous pathways connecting the thalamus with the rostral portion of the frontal cortex, usually referred to as the granular or prefrontal cortex. In general, there are three areas of attack by which this may be accomplished. In the first, by means of the leukotomy or lobotomy the connecting pathways between certain nuclear groups of the thalamus and the prefrontal cortex are severed. In the second, the caudal terminal of these pathways in the thalamus are destroyed. This procedure is referred to as a thalamotomy. In the third method, the rostral terminal, the prefrontal cortex, is ablated. This procedure is referred to as a topectomy. In addition to these three basic types of psychosurgical procedure, there have come into being a number of other modifications and technical variations in an effort to simplify the surgical technique of one or another of these methods: to reduce the surgical risk of these procedures; to make them more available for general use; to increase or to reduce the extent of the destructive procedure; and finally, to reduce the incidence of unfavorable postoperative side effects. The list of these modifications is already so long that it is almost impossible to keep abreast of them. Some of these which have attracted the greatest atten-

tion, however, should be briefly mentioned. They are cortical undercutting by means of which a surgical incision is made just beneath certain cortical areas disrupting the connections between the overlying cortex and the subjacent white matter. This is most commonly done in the subfrontal area in relation to the orbital cortex or in the superior frontal gyrus in relation to Brodman's areas nine and ten. Other areas for undercutting are also now being introduced. Freeman and Watts now utilize standard, radical, and minimum precision methods of lobotomy in an effort to achieve greater selectivity in their results. Various fractional methods of lobotomy and cortical ablations are being used by proponents who claim that their use accomplishes the desired result with minimal personality alteration. Such, for example, is the bimedial lobotomy in which only the medial portions of the frontal subcortical white matter are severed. The transorbital lobotomy which has been the subject of considerable prejudicial criticism and which unfortunately has been referred to as the "icepick" operation severs the connecting white matter in the frontal lobes by means of a stab wound through the conjunctival sac and orbital plate directly into the frontal lobe white matter. By controlled manipulation of the handle of the leukotome, its point makes reasonably accurate incisions in the white matter.

In setting up our program at Wayne County General Hospital, one of our purposes was to employ a variety of surgical procedures to determine which in our hands and in our institution proved most practicable. We have made only a beginning, having operated on thirty-two patients thus far. The first twenty-five patients were done by means of the so-called open method through large superiorly placed trephine buttons by direct visualization of the actual lobotomy. By this means all white matter in a coronal plane at the level of the sphenoidal ridge was sectioned under direct vision. We hoped that these patients would provide us with some baseline for comparison with future techniques. The second technique which we have utilized thus far in only seven patients is a blind technique, but it is much simpler and swifter so that the surgical procedure is greatly simplified compared to our basic procedure. In these seven patients, which we hope to extend to twenty-five, through superior burr holes placed on each side in the ordinary fashion, an instrument called a MacKenzie leukotome is inserted in the appropriate area of the brain, the incision is made, the instrument withdrawn, and the wound closed. This procedure should take approximately one-half hour. With this instrument a wire, like a tonsil snare, is ejected in a coronal plane from a probe which is inserted in the brain. We have not yet performed a sufficient number of cases with the second technique to compare the results, although there is no question that it is much simpler and probably as effective as the open operation which we used at first.

Conclusion

Of the thirty-two patients having undergone bilateral prefrontal lobotomy, six showed slight improvement in the sense of demonstrating a moderate reduction in the frequency and intensity of disturbed behavior. Fourteen patients were rated as moderately improved. This group of patients showed nearly complete relief of such symptoms as extreme tension, anxiety, assaultiveness, and self-mutilation. Mental deterioration is not apparent. Nine patients were greatly improved. These patients either are out of the hospital or are awaiting convalescent leave. None of these patients showed overtly psychotic behavior but lack of initiative and concern for the future was characteristic. None of them has shown any serious antisocial tendencies or any disturbance in sexual behavior so far as we know.

The number of patients operated on here to date is too small to be the basis for any statistical conclusions. Observation of these cases, however, has led us to the following two impressions. First, postoperative damage to the personality, while not as profound as it is sometimes described as being, is still sufficiently great that psychosurgery should never be used except as the very last recourse on patients faced with a hopeless prognosis in the opinion of a group of trained psychiatrists. Secondly, we have become convinced that prefrontal lobotomy is successful in a large percentage of cases in the relief of extreme tension, anxiety, and depression, and in the control of violently disturbed behavior. It has relieved much suffering in our patients and has made possible the return of a significant number of them to the community who otherwise would never have left the hospital.

Acknowledgment

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Problems in Intestinal Obstruction

By Philip Thorek, M.D.
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INTESTINAL obstruction presents a diagnostic and therapeutic challenge to both the surgeon and practitioner. The mortality continues to remain high despite the many recent advances in electrolyte balance, intestinal siphonage, caloric requirements and surgical technique. Wangensteen, Haden, Orr, Coller and many others have contributed monumental stepping stones which enable us to understand the pathologic physiology of this condition.

Since intestinal obstruction is a symptom complex and not a disease, it is not enough to make a diagnosis of "just intestinal obstruction." To approach this problem we have devised a plan whereby we can make an earlier and more thorough diagnosis, thus enabling proper therapy to be instituted more rapidly. It is necessary to ask and answer the following four questions to correctly diagnose the condition:

1. Is this an intestinal obstruction?
2. Is it strangulated or non-strangulated?
3. Is the obstruction complete or incomplete?
4. Is it a large or small bowel obstruction?

In answer to question number one: "Is this an intestinal obstruction?" we expect to find the obstructive triad, namely, distention, obstipation and vomiting. The triad may be present wholly or in part, however, its individual parts call for clarification. Since we have no standard for measuring the distended abdomen, we have decided to utilize the anatomic relationship of the umbilicus to the xiphoid process. We believe that the normal abdomen is scaphoid and not flat, hence the umbilicus is normally placed below the xiphoid. When the umbilicus is on a level with the xiphoid, the abdomen is called *flat,* and when the umbilicus is above the xiphoid, the abdomen is described as being *distended.* Therefore, when the umbilicus is on a level with or above the xiphoid, some pathologic condition exists. When such an abnormally placed umbilicus is found we consider the differential diagnosis of the seven "F's," namely, fat, feces, fluid, flatus, fetus, fibroids and "ph"antom tumors. In almost every case one of the "F's" has been found to be the underlying cause.

It is important to record the position of the umbilicus when the patient enters the hospital, and to re-check this every hour thereafter. If the umbilicus is below the xiphoid when the patient is first seen, and one hour later is found on a level with the xiphoid, this signifies early distention. In this way we can avoid the development of a late preterminal distention that so many neglected intestinal obstructions present. Regarding *obstipation,* we know that the average intestinal obstruction passes neither feces nor flatus, but we also recall that this may be lacking in incomplete obstruction as for example in Richter's hernia, in which only part of the circumference of the bowel is incarcerated. In such cases the resulting irritation and hyperperistalsis may even lead to a diarrhea which can be most misleading when one makes a diagnosis of intestinal obstruction.

Vomiting will be more thoroughly discussed under question number four. Regardless of the absence or presence of the obstructive triad, it is far more important to elicit the one pathognomonic finding of intestinal obstruction, namely, that *pain and intestinal sounds appear at the same time.* This synchronization of sound with pain differentiates intestinal colic from any other type of intermittent pain. The physician should place his stethoscope upon the patient's abdomen when he states that he is getting his pain, and if it is of an intestinal nature he will hear the rushing bowel sounds at this time.

Question number two: "Is this a strangulated or non-strangulated intestinal obstruction?" can usually be answered by the presence or absence of tenderness. Patients with intestinal obstructions do complain of colicky pain, but the strangulated lesion has pain plus localized tenderness, which is best found by the patient, who will usually locate the exact point of the pathology. The classical example of this is a strangulated inguinal hernia. The patient has diffuse pain over his entire abdomen, but will permit one to palpate it; however, he resents having pressure made over a

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From the Departments of Surgery, University of Illinois, Cook County Graduate School of Medicine, Cook County Hospital, American Hospital and Alexian Brothers' Hospital.

strangulated mass because of its exquisite tenderness. Our incision is usually determined by the location of the patient's tenderness. Another differentiating point between the strangulated and the non-strangulated obstruction is the appearance of the patient. A patient who has a strangulated intestinal obstruction is acutely and violently ill and usually is in shock or impending shock, whereas the patient with an intestinal obstruction without strangulation does not present such a dramatic picture. The flat roentgenogram may aid in the differentiation of a strangulated from a non-strangulated small bowel obstruction. If a small bowel, non-strangulated, intestinal obstruction is present, the typical stepladder pattern is observed and the valvulae conniventes are readily seen. If, on the other hand, a small bowel strangulated obstruction is present, no characteristic bowel pattern is assumed since the distended loops arrange themselves in whatever portion of the abdomen the obstruction occurs. The valvulae conniventes are not easily detected or seen because of the extravasation of blood into the strangulated loop of bowel and into the abdominal cavity.

Question number three states: "Is this a complete or incomplete obstruction?" As has been mentioned, a patient with a complete intestinal obstruction passes neither flatus nor feces per rectum, but if the obstruction is incomplete some flatus and feces may be expelled especially with repeated enemas. It is important not to become misled by the results of the first enema, since a copius movement and flatus may be expelled following its administration. This, however, is material which is distal to the lesion. If repeated enemas bring flatus and feces, then we assume that the lesion is incomplete; if the returns of the repeated washings are clear, we conclude that the obstruction is a complete one. "A "scout" film of the abdomen should be taken when the patient arrives. This immediately reveals the bowel pattern and also determines whether or not flatus is present in the region of the hollow of the sacrum. If the flatus over the sacrum is absent following repeated enemas, we consider the condition a complete obstruction, but if flatus continues to come down and appear over the sacral region, the lesion is an incomplete one. A patient with a complete obstruction will appear more ill than one with an incomplete lesion; therefore, the clinical appearance and impression is of importance.

The fourth question that must be answered is: "Is this a large or small bowel obstruction?" The most important differentiating factor to this question is whether or not vomiting is present or absent. Patients with large bowel obstructions do not vomit, but those having small bowel obstructions do. We all have seen late cases of large bowel obstructions where vomiting has been present as a late and not too distressing symptom, but in the small bowel lesions vomiting appears very early. The higher the obstruction the more fulminating the vomiting. Utilizing this one fact, we can usually differentiate the small from the large bowel obstructions. To use the word "fecal" vomiting as being descriptive of intestinal obstruction is incorrect. The term "feculent" is more descriptive, since fecal vomiting refers to a gastrocolic fistula or some similar lesion. The flat roentgenogram is used to further differentiate the small from the large bowel obstruction. It is unnecessary to stand or turn the patient or to give him any contrast media. A flat roentgenogram which can be taken with a portable machine will usually give the desired information. If the obstruction is a large bowel lesion, the roentgenogram usually reveals a large distended colon which appears as a horse-shoe or inverted "U." The rectosigmoid is the most common location for these lesions. If, on the other hand, the obstruction is small bowel in nature, the typical paralleling or stepladder pattern will be present. The history also aids in differentiating the two types of obstructions. A slow, progressive, chronic, increasing constipation speaks for a large bowel lesion, but a sudden violent attack signifies small bowel pathology. Patients with intestinal obstruction who have had previous surgery are small bowel obstructions until proved otherwise. The large bowel obstruction resulting from postoperative adhesions is a rarity. A two-quart diagnostic enema is also a help. The large bowel can usually retain two quarts of fluid plus its usual contents. If the bowel cannot take the two quarts, this speaks for a large bowel lesion.

One may make a proper diagnosis instead of just "intestinal obstruction" by using these four questions. The case, therefore, may be diagnosed as a large bowel, non-strangulated, incomplete intestinal obstruction, or a strangulated, small bowel, complete intestinal obstruction, depending upon the findings.

Treatment

We have devised a simple plan for the treatment of intestinal obstruction based on the six "S's": suction, saline, sanguine, surgery, sulfa and the "stir-'em" technique.

Suction, or gastrointestinal siphonage, has done much to lower the mortality of this condition. It has its pitfalls, however, and these must be kept in mind. It has no place in large bowel obstructions nor should it be used when strangulation is present. On the other hand, it may be curative in postoperative ileus, non-strangulated adhesive obstruction, or in obstruction associated with peritonitis; these are usually small bowel lesions. Its value as a pre-operative or postoperative adjunct needs no emphasis. To keep a patient with a carcinoma of the rectosigmoid and a large bowel intestinal obstruction on continuous siphonage is to court disaster.

Saline, an excellent form of supportive therapy, can prolong the life of a patient with an intestinal obstruction. However, it cannot cure the condition. Chloride ions have been lost in the patient who has manifested a great deal of vomiting or in whom continuous gastrointestinal siphonage has been instituted. These must be replaced, and it is mainly by the use of "physiological" saline that the patient's chloride balance may be maintained. By restoring this electrolyte balance one is able to put his patient into better condition to withstand surgery, and in this way also to lower the mortality. Saline, however, is not the only supportive therapy that the patient needs; this will be discussed subsequently.

Sanguine is used to refer to blood and its derivatives. We feel that the only place for the use of whole blood is in the replacement of lost red cells. We prefer to keep the protein balance for the patient's normal supply of plasma, serum or amino acid therapy. If the obstruction is associated with blood loss, we feel that the fluid of choice is then whole blood. In many cases of strangulated obstructions, or in cases which might necessitate extensive bowel resection, whole blood is preferred. Maintaining a normal protein level permits a patient to properly seal because of his good fibrin content. Hypoproteinemia and hyperchloridemia are two conditions which must be avoided in the case of intestinal obstruction as well as in all other surgical emergencies. Too little protein and too much chloride both produce tissue edema and permit the patient to "drown" in his own body juices. It is because of hypoproteinemia and hyperchloridemia that sutures pull out of edematous tissue. Faulty suturing material is not the only cause of intestinal leakage; this is due to poor pre-operative and postoperative care. The patient's vitamin needs must be maintained, especially the water soluble vitamins B and C which he loses readily. Vitamin C is truly the surgeon's vitamin because this is the one which is essential to sound wound healing. If a patient has a strangulation he should have immediate surgery. As has been stated, the patient will tell us where to make the incision if we permit him to reveal his most tender spot. Complete, large bowel, non-strangulated lesions require immediate colostomy for the release of introcolonic pressure. We prefer the so-called "blind" cecostomy in such conditions. This is made through an exaggerated McBurney's incision which hugs the anterior superior iliac spine. If the cecum is distended, and it surely should be in an obstructed colon, then it bulges into the wound. It is held in place by two forceps, and an iodoform pack is placed between the cecum and the parietal peritoneum. Following this stitchless procedure, the patient is returned to bed and the cecum is opened some six hours later after it has had a chance to seal off. Since the bowel wall is edematous and will not retain sutures it is unwise to directly attack an obstructed colonic lesion. It is for this reason that we leave the primary pathology alone and do a preliminary cecostomy away from the site of the lesion. For the following ten days or two weeks the patient may be deflated, prepared and then re-operated. It is at this time that a true evaluation of the pathology can be made and a resection done. The cecostomy acts as a vent in the event that an intestinal anastomosis is performed. In strangulated lesions we may be confronted with the question: "Is the bowel which has been freed viable or not?" It seems impractical to stand about placing hot towels on a segment of intestine and watch its color. Viability is readily determined if one merely flicks the bowel with the finger and watches for peristaltic waves. If it is able to contract, regardless of the color of the intestine, it is viable. Intestinal obstruction is usually associated with a transudate which is present in the peritoneal cavity; if this is bloody a strangulation is present. Therefore, if a blind cecostomy is done and a sanguinous fluid noted, we must abandon the cecostomy and explore for the presence of a

strangulated lesion. The type of anastomosis performed is purely a personal one; however, we feel that a lateral anastomosis is the safest in the hands of the occasional operator. If time is a factor, one should be familiar with the technique of the so-called quick "aseptic" end-to-end anastomosis.

Sulfa drugs have taken their place among the chemotherapeutic agents used in the treatment of intestinal obstruction. There is also a place for such allied drugs as penicillin and streptomycin. Following the surgery, we place 3 to 4 grams of sulfathiazole or sulfadiazine in the peritoneal cavity and follow this with 40,000 units of penicillin every three or four hours intramuscularly. We do know that penicillin will not affect the colon group of organisms but it will attack streptococci and staphyloccocci. Sulfadiazine is administered intravenously following the first postoperative day and streptomycin is coming into its own as the main chemotherapeutic agent against the Gram-negative rods. Sulfasuxidine and sulfathaladine will keep the bacterial count low in the intestinal tract if those drugs can be taken by mouth.

By *"stir-'em" technique* we mean early ambulation, active and passive movements and breathing exercises. The beneficial effects brought about by getting patients out of bed as soon as possible have been well proven. We do not wish to infer that early ambulation should be carried to an extreme. It is our plan to have our major surgical cases out of bed on the first postoperative day. However, each case presents an individual problem. Having the patient move about, having him take a few deep breaths every hour, and encouraging arm and leg movements all play their part in lowering the incidence of phlebothrombosis, pulmonary complications and their sequelae.

In this discussion of the subject of intestinal obstruction, only the highlights have been mentioned; however, we feel that if we approach the problem with the "Four Questions," make a diagnosis based upon these, and then summarize the treatment with our "Six S's," we should have a logical approach to a given case.

25 E. Washington Street

ECONOMIC BAROMETER

The annual report of General Motors Corporation for 1952, which was released yesterday, should be of interest to every Detroiter whether or not he is an official, employe or stockholder of the concern.

GM's operations are an important economic barometer, particularly for this area where so much of its activities are concentrated.

Last year the company's sales set a new record of $7,549,154,419, although its profits were below those of 1950. This may reflect the fact that in 1952 a preponderantly large part of GM's activities were devoted to defense work, presumably at a narrower margin of profit. About one-quarter of the corporation's sales last year were of defense products.

What is of particular public interest is the fact that out of its gross income, General Motors paid more than $1.107 billion back to various units of government as taxes. At the same time, $2.135 billion went to its workers and managers as wages and salaries.

These are stupendous figures, reflecting the giant size of "the world's largest corporation" and indicating to what extent both government and people are dependent upon its successful operation.

The statement attributed to Defense Secretary C. E. Wilson, former GM president, that "what is good for General Motors is good for the country" certainly can be paraphrased without challenge into "what is good for GM is certainly good for Detroit and Michigan."—Editorial, *Detroit Free Press*, March 12, 1953.

Editorial

HELP MAKE A 3,000 ATTENDANCE RECORD IN GRAND RAPIDS
MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
September 23-24-25, 1953

MEDICAL JURISPRUDENCE

THE *Michigan State Bar Journal* and THE JOURNAL of the Michigan State Medical Society are this month jointly presenting six papers on subjects of kindred interest. Three of these papers were prepared by members of the State Bar of Michigan. We are presenting four papers written by Doctors of Medicine, three of which the *Bar Journal* is also using.

When casting about for papers to use in this joint venture we found so many topics which were of joint interest that we wondered why such a scheme of co-publication had been delayed so long. We also found an amazing number of Doctors of Medicine practicing in Michigan, and members of our State Medical Society who are also graduates in Law.

Industrial Medicine and Surgery for February, 1953, contains an article "Expert Testimony" by Carey P. McCord, M.D., of Ann Arbor, which all should read who have any occasion to give expert testimony.

We hope our readers will enjoy this effort at journalism a little out of our regular type.

ADOPTION AND THE DOCTOR OF MEDICINE

FOR A LONG time the Department of Social Welfare, the Probate Courts, and the Maternal Welfare Committee of the Michigan State Medical Society have considered the problems, risks and frustration in the many and varied attempts to accomplish the adoption of a child. The administrative personnel of the Department and the Medical Advisory Committee from the Michigan State Medical Society have spent many hours in study. The result was an editorial we published in July, 1952, page 879.

It was decided to publish a condensed statement of the legal and social requirements covering this subject in order to give our members as precise a digest as possible in cases where some of them have been accustomed to aid in the adoptive process. The proposed statement was presented to the Executive Committee of the Council who authorized publication, with the suggestion that a Probate Judge be also consulted.

The Editor submitted the manuscript to Edmund R. Blaske, Probate and Juvenile Judge, Calhoun County, who made sharp and constructive criticism, suggesting more detail. This has been done in the article on another page. Judge Blaske also mentioned that there are provisions for financial assistance to needy and expectant mothers under the Afflicted Children's Act and cautioned specifically about the desirability of legal counsel and assistance in the court procedures. He said "direct placement or arrangement by a physician will require a great deal of the physician's time in court attendance and may involve great disappointment and emotional upset to the adopting parents if the court is compelled to deny the particular adoption on the ground that the best interests of the child would not be served by granting the adoption."

Judge Blaske complimented the Michigan State Medical Society for the statement of the problem in the July, 1952, editorial as being very exact and forceful. W. J. Maxey, Director of the Department of Social Welfare, writes "Judge Blaske has done an outstanding job in Calhoun County."

We are happy to present this syllabus on the adoption problem in this number of THE JOURNAL because of the close tie-in with Medical Jurisprudence.

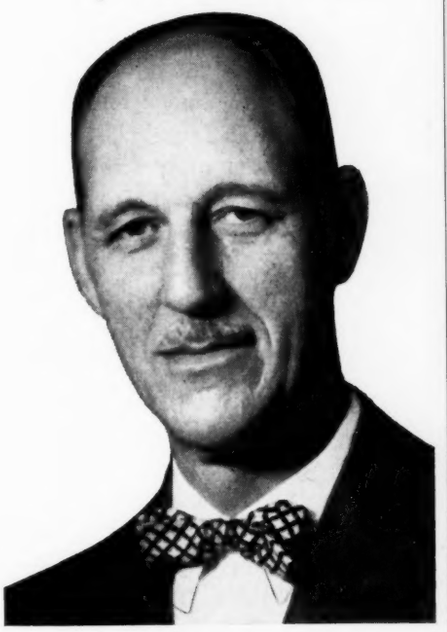
REASSURING GOOD WILL

THE MEDICAL profession of Michigan should guard well the considered and favorable public recognition which is now ours. As a profession many accomplishments are a credit to us.

In Michigan we are practicing the very best medical science known. Many of our doctors are leaders and have also been pioneers in medical research and advancement. Our medical teaching facilities are handicapped by limitation of numbers of students we can educate, but the quality is not surpassed, and the facilities for increased numbers is being rapidly expanded. In Ann Arbor a new Out-patient Clinic building is now in use. In Detroit progress on the new Medical Science build-

Honesty—Integrity—Skill—These Spell Good Public Relations

President's Message



In a recent issue of one of the popular news magazines appeared an interview with Paul R. Hawley, M.D., director of the American College of Surgeons. It prompted a great deal of discussion among medical men and even some bitter criticism. These remarks concerned principally the complaint that the general practitioner is being demoted in his capabilities in the eyes of the public. That is regrettable, because at this time we are attempting to interest more young medical men to enter general practice, and there is a definite need for them. Many are doing creditable surgery to the limit of their proven ability.

On the other hand, Doctor Hawley's statements contain a number of truths that only we can know whether or not they exist in our community. If they do, it is our bounden duty to see that they are corrected as expeditously as possible. Mention is made of medical audits of their own work done by the doctors themselves, of the rising standards of hospitals, and of grievance or mediation committees. An increasing liaison between the public and the medical profession through the county society must be obtained if we are to let the people know what we are doing to combat the evils in the practice of medicine, no matter how small the incidence of these grievances may be. No amount of public relations activity, as important as it is, can ultimately replace the honesty and integrity, combined with the skill, of the individual physician. William L. Bender, M.D., past president of the San Francisco Medical Society, has succinctly described our situation: "Provide the best possible medical care at the lowest possible cost and make sure everybody knows about it."

R. J. Hubbell

President, Michigan
State Medical Society

ing is very satisfactory. Michigan is now also attracting a considerable number of graduates from other states, in addition to those educated in our own schools. This is evidenced by the new registrants reported in recent numbers of THE JOURNAL.

Doctors of Medicine practicing in Michigan have made a record for themselves in a practical and successful solution of the problem of health care for their patients and the people of our state. We have explored a brand new field of economics and proven that health services are insurable services which can be planned for on a prepayment basis. We have been so successful that independent insurance companies who formerly refused are now glad to enter the field to sell such insurance. Our Blue Cross and Blue Shield have made prepayment health care available to every person in the state who has a small income, sufficient to pay the modest rates charged. At first the plans sold their policies by groups, but now state-wide private subscriptions are accepted at stated times every year. This project of the profession has been one of the most worthwhile accomplishments in the field of Medical economics.

Michigan holds another favorable position. A recent survey of medical incomes made by Medical Economics ranks Michigan first in the matter of median net income per Doctor of Medicine. The first five States are Michigan, $16,276; Washington, $16,200; Kentucky, $15,649; Kansas, $15,430; and Illinois, $15,100. The next group of states with net median income in the $14,000 bracket are, in order: North Carolina, Ohio, California, Virginia, Indiana, Texas, Missouri, Nebraska, and Florida. Surveys have also shown that the medical profession in this Great Lake States area is especially favored in that the items of costs of practice, rents, et cetera are slightly lower than the general average.

Michigan was a pioneer in the matter of medical public relations. Early we began devising other physician-patient-relation programs in addition to the prepayment plans. We have had grievance committees in our county medical societies for many years. Patients who believe they have a complaint can come to these committees, have a hearing and get an adjudication. The number of such complaints has not been great, and the facility with which they could be satisfied has been very gratifying. Other societies and other States have quite generally adopted similar plans, and found the rewards to be well worth the effort.

Such are some of the plus signs in our ledger. What of the other side?

DON'T ROCK THE BOAT

ITEMS HAVE appeared recently in the public press and national magazines tending to encourage a belief among people in general that all is not as it should be in the ranks of the medical profession. Anything which seems to throw doubt on the honesty and devoted zeal of the profession is not only a disservice to the whole population but is grist for the socializers.

As quoted in one of the national magazines the Director of the American College of Surgeons, Dr. Paul Hawley, called public attention to the charge that all surgeons are not honest. He mentioned fee-splitting, the bane of the American College of Surgeons, which is prohibited by law in Michigan and several other States and something the profession has been trying to stamp out for as many years as our oldest members can remember. Ghost surgery, where one man does the work and the patient thinks another did it; and unnecessary operations, such as appendectomies without pathology, were included in this criticism which was intended to be constructive but which provoked a plethora of adverse comments in regard to the profession, including admissions that the charges were true and denials that they are justified any more.

Dr. John T. T. Hundley, Past President of the Medical Society of Virginia, sponsored an article in the March number, *Ladies Home Journal* "Can We Trust ALL Our Doctors?" He discusses primarily the question of incompetence and malpractice. He charges that worthy claims for damages due to these faults are not possible of court action because no doctor will testify against his fellow, thus defending the incompetent and preventing malpractice suits, and the offender is allowed to continue his practices. The doctor says fortunately the number of such cases is rather small, but he details many, with comments, leaving the impression there is a grievous condition which is not being solved by the profession. Such stories certainly give plausibility to the ambulance chasing type of legal mind which sees profit in such law suits. This article would have been well placed if presented to the group of our profession who are culpable. Given to the general public it has stirred up comments not friendly.

Another type of medical shortcoming has received a mixed interpretation. During the past

(Continued on Page 461)

Independent Medical Experts to Testify in Injury Cases

In a move which may develop into a nation-wide model for the solution of the problem of conflicting medical claims by plaintiffs and defendants in personal injury cases, the State Supreme Court in New York County is putting into effect a plan by which medical societies will furnish top-notch independent experts to aid in settling such disputes.

Presiding Judge David W. Peck of the Appellate Division in Manhattan and the Bronx announced that the plan would be tried out as an experiment for one year, in the Supreme Court in New York County, starting December 1. The plan will be financed by a grant of $40,000 given equally by the Alfred P. Sloan Foundation and the Ford Motor Company Fund.

Explaining that the plan is aimed at "better and quicker justice, which amounts to juster justice," Justice Peck expressed hope that it might become "a historic milestone in judicial progress —a pattern for the court system throughout the nation."

The New York Academy of Medicine and the New York County Medical Society agreed, under the plan, to appoint a panel of sixty to seventy experts in various branches of medicine. The specialties will include orthopedics, neuro-surgery and neurology, psychiatry, traumatic surgery and other fields.

In instances where medical claims differ widely in a pre-trial consultation, the Supreme Court justice will assign an expert from the panel to examine the plaintiff. The expert's report will go to the court and to the opposing lawyers. If necessary, the expert will be subject to call at the trial.

Justice Peck expressed hope that the plan would have a "psychological and prophylactic effect" in inducing medical experts for both sides to moderate their claims, since they might be reviewed by an outstanding authority in their own field. He added that, in any event, the expert's findings will be of major value to a judge and jury hitherto confused by a system in which a plaintiff's doctor may tend to describe his patient as just about killed while the defendant produces a doctor who hardly finds scratches.

The new plan is one of a number of steps being taken to speed the handling of cases in the Supreme Court in New York County. As of last spring the oldest tort cases, principally negligence actions, reaching jury trial in Manhattan were as much as four years old. Justice Peck hopes that a "road block" of cases filed before April, 1949, when new screening rules took effect, might be cleared away by the end of the year. This would bring delays down to three years, with hope of trimming them down rapidly thereafter. Various measures have already reduced the pending cases in New York County from 13,000 a year ago to about 7,500 now.

Pointing out that half the time of a trial in a personal injury case is taken up by conflicting medical testimony, Justice Peck credited Supreme Court Justice Bernard Botein with originating the idea of independent medical experts almost a year ago at a meeting on court problems.

Justice Peck conferred last spring with Dr. Howard R. Craig, director of the New York Academy of Medicine, and said *the medical profession ought to team up with the legal profession to attack the problem. At a subsequent meeting between a dozen judges and doctors, the latter at once accepted the responsibility and challenge,* Justice Peck said.

He said the judges wanted power to assign the medical experts to take certain cases at certain times, *so they wanted the doctors paid.* He said the feeling was that neither plaintiffs nor defendants should be asked to bear the cost of the experimental period.

Believing that the plan might develop into something worthwhile as a pattern for the whole country, both the Ford and Sloan foundations offered to finance it. The $40,000 budget for the first year was based on the estimate that the independent experts would be invoked for 500 or more examinations.

There are about 5,000 personal injury cases a year in New York County Supreme Court, representing about 80 per cent of its work. During the past year about 30 per cent have been settled at pre-trial conferences.

Justice Peck explained that *the doctors will be*

(Continued on Page 462)

Reprinted by permission from the *Journal of the American Judicature Society,* December, 1952.

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

POLIO PREVENTION PLANS

The department expects demands for immune serum globulin for use in the prevention of paralytic polio to increase sharply as the polio season approaches. Equitable distribution of the limited supply will undoubtedly present difficult problems.

In preparation for handling the situation, the department has asked local health officers to expedite reports of polio cases so that the state office may keep in constant and close touch with the prevalence and distribution of the disease. The department will, in turn, report to the National Office of Vital Statistics, the reports to serve as a basis for determining Michigan's share of immune serum globulin.

The Office of Defense Mobilization has assumed responsibility for co-ordinating the distribution, in the National Blood Program, of available supplies of immune serum globulin for use in the control of paralytic poliomyelitis, infectious hepatitis and measles.

Main supplies of gamma globulin are being made available by the American National Red Cross, the Department of Defense and the National Foundation for Infantile Paralysis. Commercial producers have made available their existing inventories and their next six months' production and the Foundation will purchase this supply and turn it into the common distribution system.

The panel of medical authorities set up by the National Research Council is at work on a plan for making the most effective use of the available supply of gamma globulin. Dr. Hugh Leavall of Harvard University is chairman of this panel. The plan provides for distribution of the central supply to state health officers, who will be responsible for its final use.

An allotment to each state is contemplated, beginning May 1, based on the median number of cases reported during 1947-51. This was not a high year for Michigan. Supplies over and above this basic allotment for the year will be determined on the basis of emergency and epidemic need.

GAMMA GLOBULIN ALLOTMENT FOR MEASLES SET

The department has been notified that its 1953 allotment of immune serum globulin for use in control of measles and infectious hepatitis has been set at 60,900 cc.

The allotment was calculated as three times the median number of cases of measles reported during 1947-51. The median year happened to be a low one. The department distributed 146,000 cc. of gamma globulin during 1952, so the 1953 allotment will probably be inadequate. Better reporting of cases would raise the allotment.

The Office of Defense Mobilization stated that the allotment will be reviewed when the early experience of 1953 can be assessed, and an additional supply made available if indicated.

LEADERSHIP TRAINING FOR PARENT EDUCATION

Regional institutes to prepare teachers for work with classes of expectant parents will be held in April at St. Mary's Lake and at Haven Hill. In accordance with requests of participants in the institutes held last year, the emotional aspects of expectant parenthood will be stressed this year. Outstanding authorities will lead the discussions.

The institutes are a part of the department's program of leadership training to meet the widespread demand for education for expectant parents.

MAY DAY WILL BE CHILD HEALTH DAY

For the twenty-fith year, May Day has been declared to be Child Health Day by presidential proclamation. This year, emphasis will be placed upon the emotional, social and spiritual growth of children.

"CHEERS FOR CHUBBY" SLATED FOR MICHIGAN

The eight-minute animated color cartoon, "Cheers for Chubby," produced in Hollywood for the Metropolitan Life Insurance Company in co-operation with the United States Public Health Service and the American Medical Association, will be shown in Michigan theaters in the near future. The Michigan State Medical Society and the Michigan Heart Association are scheduled to join with the Michigan Department of Health in sponsoring the statewide showing of the film.

How and why overweight people should reduce is the subject of the film. It has been shown in all but seven of the states, and Michigan is one of the seven.

Important messages are presented in the advertisements in our journal each month. New products are announced from time to time and information is presented regarding the use of products featured. Other types of ads emphasize services rendered and commodities offered that may be used in your practice, in your office and in your home. Doctor, you can rely on the statements and facts presented. We aim to include only ethical advertisements in our journal. Please tell the advertisers that you saw their ads in THE JOURNAL of the Michigan State Medical Society.

Inhibition of Excess Parasympathetic Stimuli in Peptic Ulcer with Banthine®

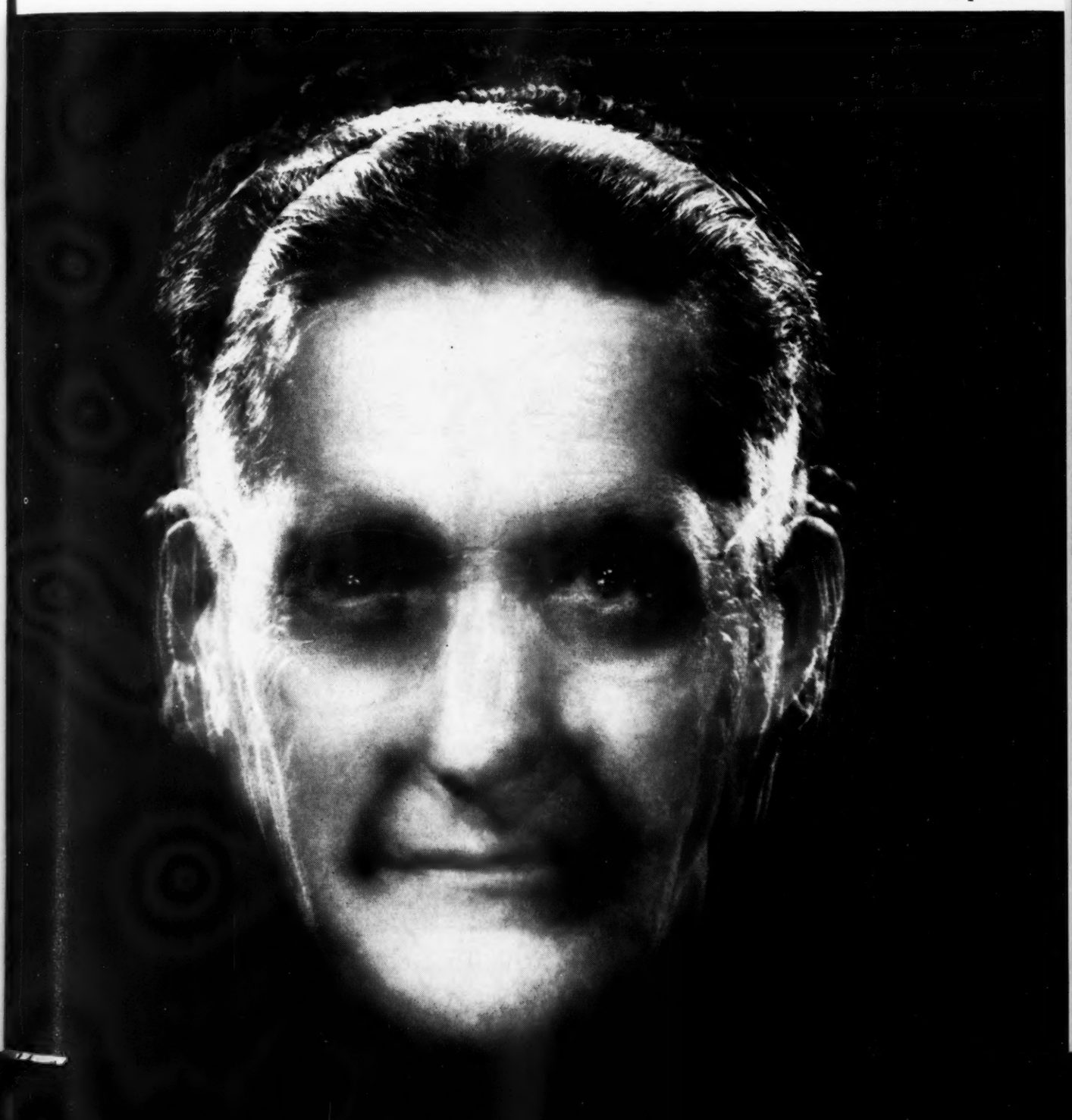
Medical literature now contains more than 200 references to the beneficial role of Banthine Bromide (brand of methantheline bromide) as evidenced by a marked healing response of peptic ulcers. Rapid symptomatic improvement, particularly with reference to pain relief, is followed by roentgenographic demonstration of crater filling.

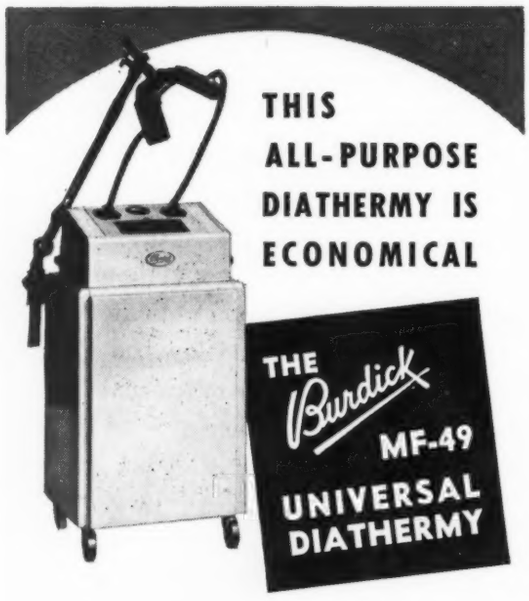
The therapeutic action of the drug in decreasing hypermotility and hyperacidity, together with the remarkable early subjective benefit, is indeed a desired approach in ulcer management.

Treatment is individualized to the patient's needs. One or two tablets (50 to 100 mg.) is administered every six hours, around the clock, in conjunction with appropriate diet control and antacid medication as indicated.

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In Memoriam

HERMAN F. ALBRECHT, M.D., of Detroit, died February 4, 1953, at the age of fifty-nine.

Dr. Albrecht, a gynecologist, was graduated from the Wayne University College of Medicine in 1916. He is survived by his wife, Stella, and two children.

WILLIAM FIEDLING, M.D., of Norway, died February 6, 1953, at the age of fifty-two.

For the past twenty-four years Dr. Fiedling served the communities of Norway and Vulcan. He was graduated from the Northwestern University Medical School in 1928. He interned at West Suburban Hospital in Oak Park, Illinois.

He had served on the Norway township school board —a position he assumed shortly after his arrival in the community and which he held until his death. He also served on the Norway board of education. Dr. Fiedling was serving as President of the Dickinson-Iron County Medical Society. He was also a member of the Public Relations Committee of the Michigan State Medical Society and on the Board of Pinecrest Sanatorium at Powers.

He is survived by his wife, a daughter, Sally, two sons, David and Michael. He also leaves two sisters and two brothers.

NEWTON H. GREENMAN, M.D., of Decatur, died January 18, 1953, at the age of eighty.

Dr. Greenman, who retired in 1949, had practiced medicine for fifty years. He was graduated from the University of Michigan Medical School in 1898 and began his practice in Fairmount, North Dakota. He came to Decatur in 1934.

Dr. Greenman is survived by his wife, Christine, and two sons. They are Rial Greenman, serving in the U. S. Navy at Norfolk, Virginia, and George Greenman, a student at the University of Michigan Medical School.

BASTIAN KRUIDENIER, M.D., of Detroit, died February 2, 1953, at the age of sixty-two.

He had practiced medicine in Detroit for twenty years following his graduation from the University of Michigan Medical School in 1932. Dr. Kruidenier interned at Highland Park General Hospital. He was a member of the Wayne County Medical Society.

Dr. Kruidenier is survived by his wife, Edna; two sons, Francis J. Kruidenier and Lt. (j.g.) John R. Kruidenier; and a daughter, Mrs. Raymond Gauss.

GEORGE J. REBERDY, M.D., of Detroit, died February 3, 1953, at the age of sixty-eight.

For the past forty-two years he had practiced medicine in Detroit, first as a general practitioner, then after postgraduate studies in Vienna in 1924-25 as an obstetrician and gynecologist. He received his medical degree from the Detroit College of Medicine and Surgery in 1910.

He was a member of the staff of Harper Hospital, Detroit, from 1910 to 1912. Later he joined the staff of

Say you saw it in the Journal of the Michigan State Medical Society

Providence Hospital, Detroit, in 1913 and remained on the staff until his death.

Dr. Reberdy is survived by three children. They are Nancy Reberdy, Mother Janet Reberdy, R.S.C.J., and George K. Reberdy, M.D., a captain in the U. S. Air Force Medical Corps. He also leaves two sisters and three brothers.

HERMAN A. RIGTERINK, M.D., of Kalamazoo, died February 5, 1953, at the age of eighty-three.

Before retiring in 1946, Dr. Rigterink had served the community of Kalamazoo since 1915. Previous to that he had practiced in Zeeland following his graduation from the University of Illinois College of Medicine in 1907.

Dr. Rigterink was a Life Member of the Michigan State Medical Society and a retired member of the Kalamazoo Academy of Medicine. He had also served on the staffs of Borgess and Bronson Hospitals.

He is survived by his wife, Sena, and two sons, Hollis J. Rigterink, of Lansing, and Gerald H. Rigterink, M.D., of Kalamazoo. He also leaves four brothers. They are George H. Rigterink, M.D., of Hamilton; John W. Rigterink, M.D., of Grand Rapids; Albert E. Rigterink, of Berrien Springs; and Henry Rigterink, of Hamilton.

EDWARD SAWBRIDGE, M.D., of Stephenson, died February 1, 1953, at the age of ninety-two.

Dr. Sawbridge, an Emeritus member of the Michigan State Medical Society, had served the community of Stephenson in the practice of medicine for fifty years before his retirement ten years ago. He was graduated from Rush Medical College, Chicago, in 1893 and came to Stephenson after serving an internship at Cook County Hospital in Chicago.

He was a former president of the Menominee County Medical Society and the Upper Peninsula Medical Society.

During Dr. Sawbridge's lifetime in Stephenson he was also active in civic affairs. He served on the township school board and the village board as well as being instrumental in establishing the Pinecrest Tuberculosis Sanatorium at Powers. Dr. Sawbridge was a member of the Sanatorium Board of Trustees from the time of its founding in 1921 until his death.

He is survived by a son, Robert, of Wisconsin, and three daughters. They are Mrs. John Henes, of Menominee; Mrs. Harry Butts, of Stephenson; and Miss Irene Sawbridge, of California. He also leaves a sister, Mrs. Frederick Luke, of Centralia, Washington, seven grandchildren, and six great grandchildren.

Some acute cases of leukemia present such a uniform picture of extremely immature cells, both in blood and marrow, that they can only be called stem-cell leukemia.

* * *

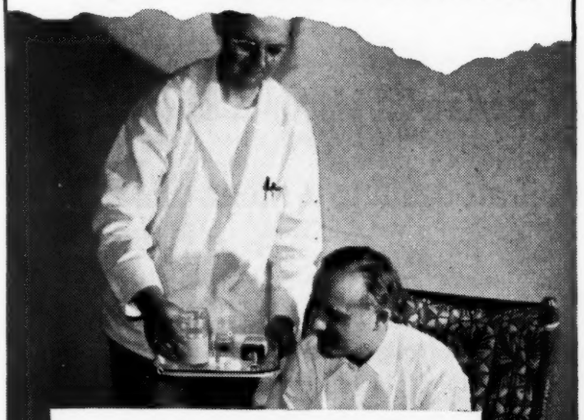
Any form of radiation may be dangerous in acute leukemia, except minimal employment on small fields for relief of bone pain, swollen tonsils, unhealed biopsy wounds, or cutaneous inflammatory lesions.

* * *

It is incumbent upon practitioners to reduce as much as possible the wide diagnostic hiatus between onset and discovery of leukemia.

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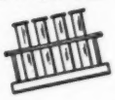
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Communications

Mr. Wm. J. Burns, Executive Director
Michigan State Medical Society
Lansing, Michigan

Dear Mr. Burns:

The Council of the Michigan State Medical Society requested us to search the law covering the question of filing certificates of registration of doctors of medicine, and to communicate our opinion to you in relation thereto.

We are in entire accord with the expressions made by you in your June 23 letter to the County Clerk of Washtenaw County, Ann Arbor. It is our opinion after careful examination of the applicable law, that the requirement for the filing of a certificate of registration of the doctor of medicine, or a certified copy thereof, is solely with the clerk of the county in which such doctor resides. This procedure is provided in Section 338.54, C.L. 1948.

We are further of the opinion that a doctor of medicine is not required to file his certificate of registration, or certified copy thereof, with the clerk of any county other than that of his residence, even though his practice may extend into another county.

Very truly yours,
J. JOSEPH HERBERT, *Legal Counsel*
Michigan State Medical Society

October 21, 1952

* * *

Dear Dr. Haughey:

Again I want to congratulate you on the work you are doing on our State Medical Journal. The January Heart Number is one of the best. The honor extended to Dr. Wilson was one surely due this man who has done so much for our profession. Thanks for your fine work.

Now then, I know that you are in for anything helpful to good health, and so I want to establish a new department in your JOURNAL. Put it under this name if you will,— "The Michigan Medical Society Fire Department."

For years I have been disgusted with some of the habits of the medical profession. If any class of men should try to live up to what they are preaching, the doctors should be the ones to do so. For years the smoking habit has been spreading, especially the cigarette habit. Years ago we heard of some efforts made to fight this malicious habit, but very little is heard now but silence. It is an ordeal for any physician who does not smoke, to stay in some of the medical meetings and breathe the stinking stuff that fills the room. Some of our more recent meetings have made it hard for these cigarette suckers because the Fire Marshall ordered no smoking. It is amusing to watch some of these habitues as they lean over on the sly and light up for a puff or two. The persistence of this thumb sucking, sugar teat, would not be so bad, if it were not doing real damage to their bodies.

Recently, I stirred up a hornet's nest at a blood clinic held in Saugatuck. Someone knowing my allergic rebound to cigarettes got me off on my little lecture. I told them that some years ago a chemistry professor in the University of Illinois had tested all the leading brands on the market and found some form of narcotic in all of them. About three years ago Dr. Curtis of Ann Arbor came to our Allegan County Medical meeting and gave us a talk on the heart. He said they had proved at the University Hospital that cigarette smoking was largely the cause of coronary heart disease as well as Buerger's disease. More recently the great increase of a formerly



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rather infrequent disease, cancer of the lung, has been ascribed to this habit.

After making my little speech, the nurse who was conducting the clinic gave me the "Ha Ha." You know it hurts when you get the laugh. I then asked her if she had any children, whether she would like to have them watch the ads of cigarettes and liquor that are continually poured out on the public in television programs? She did not answer me. Later, one of the clinic party told me that this nurse would smoke two at a time, if she knew how to do it.

Now what I am getting at is, that these nurses, who were collecting blood to save and extend life, were setting an example of how to destroy life and thinking it smart. It seemed like a travesty on what the medical profession stands for.

Two days ago I received from the State Medical Department a communication in regard to a survey of homes with heart patients. It is all very good, but it struck me that the nurse or person making the survey might be smoking a cigarette and perhaps offer one to the patient while she was being shown how to change the kitchen and shelves to save steps. Consistency, thou art a jewel.

As an editorial writer, I know you can hit this thing much harder than I could ever put it across. Some years ago I heard a returned missionary from China, tell that the cigarette manufacturers slogan in China was "a cigarette in the mouth of every man, woman and child." In their advertising on a large billboard they had pictured the Holy Supper, with the statement underneath, that if Judas had used this brand of cigarettes, he would not have betrayed his Master.

Their advertising has been just as revolting here at home. The medical profession has cleaned up many unhealthy conditions. It would seem now that there is one place they should take the lead in cleaning up their own back yard. If we do not take action, someone will be saying that these cigarette smoking doctors are the "Judas goats" leading the public on to the cigarette slaughter.

You have known me long enough to know that I am not a crank, saint or a prude and far from it. Let's get our fire department organized and put out the fire.

With the best of wishes,
EUGENE T. BRUNSON, M.D.

Ganges, Michigan
February 26, 1953

* * *

William Bromme, M.D.
Council Chairman, MSMS
Detroit

Dear Dr. Bromme:

On behalf of the Wayne chapter of the Student American Medical Association, I wish to thank you personally, and through you, the Michigan State Medical Society, for again sponsoring a delegate and an alternate to the National House of Delegates Convention of the SAMA.

The Wayne delegation was priviledged to participate in the SAMA affairs in several matters:

1. Norm Henderson, along with other national officers of the SAMA, had his office extended until June, 1953, the new date for all future annual meetings of the SAMA.
2. The Group from Wayne proposed the following resolution which was unanimously adopted by the convention and appeared in the February 1953 issue of the Student AMA Journal:

   "Whereas, the medical profession has to some extent, sustained increasing adverse comment regarding fees and social and medical responsibilities; and

   Whereas, This criticism may be averted in part by stressing in the medical curriculum of the under-

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graduates the ethics of medicine and the moral principles which support it; and

Whereas, Several medical schools, while listing a course in medical ethics in their catalogs and bulletins, in actuality do not now offer such a course for the instruction of medical students; and

Whereas, It is consistent with the founding purposes of the SAMA to improve standards of medical education and to inculcate in future doctors of medicine the ethics of their profession; Therefore be it

RESOLVED, That the SAMA respectfully request the deans of the several medical schools that where inadequate and ineffective courses in the study of medical ethics exist, and the study of supporting moral principles is deficient, that such a course be included in the best interests of the medical profession and the people whom it serves."

3. I was fortunate enough to receive the chairmanship of the Committee on By-Laws. As a result of the work of this committee several by-laws and amendments were presented and accepted which improved the constitution of the SAMA. About 14% of the published "Proceedings of the Annual Meeting of the SAMA" is devoted to report of this committee which I presented to the convention.
4. Both Norman Henderson and I broke into print. The national publication of the Organization, the *Journal of the SAMA*, carried pictures of us both in different parts of the magazine identifying our capacities in the national organization and stating that we were from Wayne Medical School.

Dr. Bromme, if you wish to see the "Proceedings, et cetera" or wish me to forward it to any interested member of the Michigan State Medical Society, our sponsors, you have only to direct me.

In this letter I am thanking you for your warm, perennial, personal interest in Medical Students at Wayne and I wish to thank you also in your official capacity as an officer of the Michigan State Medical Society. I know you will convey our indebtedness and gratitude to the proper members, committees, and/or officers of your Society on our behalf. The interest of your Society in medical student affairs is most encouraging and flattering. We do sincerely thank the Michigan State Medical Society for their very kind second annual check to defray expenses of the delegate and alternate to the SAMA national convention.

I hope that the points of our participation in the convention enumerated above appear not too immodest. Please understand that we only mean to indicate to you and the Michigan State Medical Society that as you gave us the opportunity to attend the convention so we attempted to take maximum advantage of the privilege.

Respectfully yours,

ROBERT M. NALBANDIAN, *Delegate to 1952 SAMA National Convention*

Detroit, Michigan
February 24, 1953

* * *

Dear Dr. Haughey:

You have my permission to use any part of my letter in any way you see fit.

However, the object of this letter is to compliment you and the Medical Society on the most understanding and progressive statement on the matter of adoption that I have read or heard a physician utter. The editorial is certainly something that should be widely publicized because it clearly points out the many problems involved in child placement.

With your permission, I would like to quote from the editorial as the occasion arises.

Sincerely yours,

EDMUND R. BLASKE
Probate and Juvenile Judge

Marshall, Michigan
February 24, 1953

Say you saw it in the Journal of the Michigan State Medical Society



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MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
September 23-24-25, 1953

MICHIGAN AUTHORS

F. L. Rector, M.D., Secretary of the MSMS Cancer Control Committee, is the author of an article entitled "The Physician's Responsibility in Cancer Control" which appeared in the February, 1953, *Journal of the Student American Medical Association.*

E. S. Gurdjian, M.D., and **J. E. Webster, M.D.,** of Detroit, are the authors of an article, "Strokes Resulting From Internal Carotid Artery Thrombosis In The Neck," published in *The Journal of the American Medical Association,* February 14, 1953.

Jack Lapides, M.D., and **Austin I. Dodson, Jr., M.D.,** of Ann Arbor, are the authors of an article, "Observations on Effect of Methantheline (Banthine) Bromide in Urological Disturbances," published in the *Archives Of Surgery,* January, 1953.

J. M. Sheldon, M.D.; K. P. Mathews, M.D., and **R. G. Lovell, M.D.,** of Ann Arbor, are the authors of an article, "Skin Tests In Atopic Disease," published in *The Journal of the American Medical Association,* March 7, 1953.

Henry K. Ransom, M.D., F.A.C.S., of Ann Arbor, is the author of an article, "Cancer of the Stomach," published in *Surgery, Gynecology and Obstetrics,* March, 1953.

Robert F. Ziegler, Conrad R. Lam, and **Richard E. Shipley** of Detroit, are the authors of an article, "The Diagnosis and Treatment of Congenital Cardiovascular Defects in Infants," published in *Postgraduate Medicine,* February, 1953.

* * *

The "Past Presidents' Room" at MSMS headquarters in Lansing was formally open during the Annual County Secretaries Conference on February 25.

The panel of photographs of all MSMS Past Presidents was displayed in the first floor room of the Executive Offices. The pictures date back to 1866.

All MSMS members are cordially invited to visit the MSMS home and exhibit when in Lansing.

* * *

Alexis St. Martin, whose open stomach furnished Dr. Beaumont an opportunity for studying directly the processes of gastric digestion, is still living at St. Thomas, Canada. He is described as hale and hearty at the age of 87, though the orifice in his stomach is still open. It will be remembered that the wound was the result of a charge of buckshot accidentally received, laying open the stomach so that food could be injected and removed at will by the attending physician, whose observations were of such great value to medical science. It is now 57 years since the accident occurred.—Extract from *Scientific American* of August 2, 1879.

* * *

A Bruce H. Douglas Memorial Fund, in honor of the late Dr. Douglas who served Detroit as Commissioner of Health, has been created by the Woman's Committee of the Tuberculosis and Health Society of Wayne County. Qualified candidates may be awarded up to $2,000.00 for graduate study in health education or in medical social work. For information, write the TB and Health Society, 153 E. Elizabeth, Detroit 1, Michigan.

* * *

The AMA Special Committee to be of assistance to the Federal Security Agency is composed of E. L. Henderson, M.D., Louisville, Kentucky, Chairman; L. H. Bauer, M.D., Hempstead, New York, Vice Chairman; Edward J. McCormick, M.D., Toledo; Dwight H. Murray, M.D., Napa, California, and F. J. L. Blasingame, M.D., Wharton, Texas. Walter B. Martin, M.D., Norfolk, Virginia, is the alternate member. This committee was appointed following the February 3 meeting with Federal Security Agency Administrator Oveta Culp Hobby who asked the AMA representatives for the appointment of such a committee.

* * *

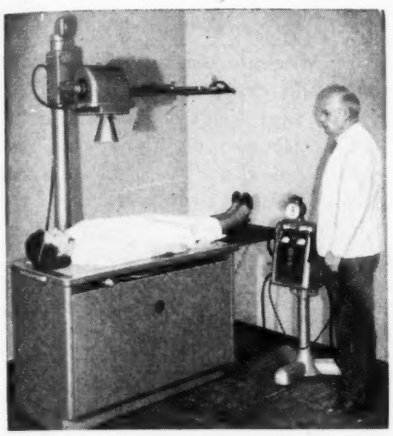
Krebiozen: The Illinois Legislature will investigate Krebiozen, the controversial cancer drug, first introduced by Andrew C. Ivy, M.D., Chicago. Hearings are scheduled to be held in Springfield.

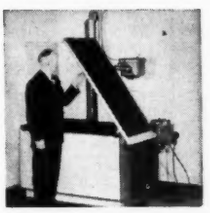
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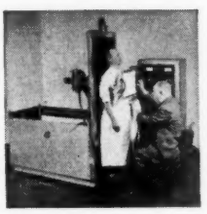
The special meeting of the AMA House of Delegates, in Washington, D. C., on Saturday, March 14, was called to determine the policy of the AMA in relation to President Eisenhower's proposal to make the Federal Security Agency a government department with Cabinet status (including health and education).

The March 14 meeting of the House of Delegates was the eighth to be held in the nation's capital; the fourth such special meeting in the association's history; the first time that a special meeting of the House of Delegates ever was held outside of Chicago.

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The President's reorganization plan calls for elevation of the Federal Security Agency to a Cabinet Department of Health, Education and Social Security. This proposal would come up for Congressional action before the next regularly scheduled meeting of the House of Delegates in June, 1953—so the special meeting was called in March.

* * *

Willard F. Greenwald, who had many friends in the medical profession because of his work as a scientific consultant, passed away at his home in Woodmere, Long Island, New York, on February 28, 1953. Mr. Greenwald, who carried on pioneering research for industrial firms, was best known for his work with Philip Morris and Company. He is survived by a widow, a daughter, and a son, Willard F. Greenwald, Jr., M.D.

The medical profession has lost a good friend in "Bill" Greenwald.

* * *

The MSMS Child Welfare Committee, at its February 11 meeting, requested that the following important item be published in JMSMS.

"For the purpose of detecting and treating retro-lental fibroplasia, the Child Welfare Committee recommends that all premature infants under four pounds be examined by an ophthalmologist within two weeks following birth, and periodically at least every two weeks thereafter."

* * *

Hack Shoe Company has purchased a lot on Livernois Avenue, a block north of its present store.

It is planned to commence building immediately, according to Leonard Hack, secretary-treasurer of the thirty-seven-year-old firm.

The move will provide more stock space as well as a larger fitting room, needs dictated by the highway satisfactory growth in the stores' business since the opening of the firm's Livernois Branch three and one-half years ago.

* * *

Warren R. Mullen, M.D., Muskegon, first President of the Student American Medical Association, who was graduated from the University of Michigan Medical School in June 1952, will begin the practice of medicine in Pentwater, July 1, 1953. Dr. Mullen is a graduate of

Beaumont Memorial. "I intended giving $50.00 to the Beaumont Memorial Fund but Dr. Otto O. Beck's statement, 'A little from many' influenced me in giving only $10.00 as I felt every doctor of medicine in Michigan would surely over-subscribe the sum required to restore the old building on Mackinac Island.

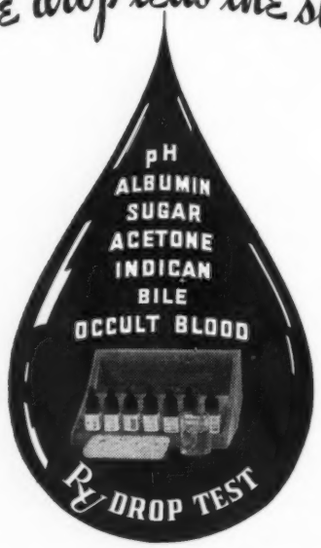
"Perhaps others acted as I have for the same reason.

"I am enclosing check for $40.00 with the prayer that the Spirit of Beaumont will inspire our Michigan profession to raise the required amount proudly and quickly.

"So—sincerely,

ROBERT W. GILMAN, M.D., Detroit."

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SURGERY—Intensive Course in Surgical Technic, two weeks, starting April 13, April 27, May 11.
Surgical Technic, Surgical Anatomy and Clinical Surgery, four weeks, starting June 1.
Surgical Anatomy and Clinical Surgery, two weeks, starting June 15, August 17.
Gallbladder Surgery, ten hours, starting April 20.
Surgery of Colon and Rectum, one week, starting April 13.
General Surgery, one week starting May 4.
General Surgery, two weeks, starting April 20.
Thoracic Surgery, one week, starting June 8.
Breast and Thyroid Surgery, one week, starting June 22.
Esophageal Surgery, one week, starting June 22.
Fractures and Traumatic Surgery, two weeks, starting June 15.
GYNECOLOGY—Intensive Course, two weeks, starting April 20.
Vaginal Approach to Pelvic Surgery, one week, starting May 4.
OBSTETRICS—Intensive Course, two weeks, starting June 8.
PEDIATRICS—Congenital Heart Disease, two weeks, starting May 18.
Cerebral Palsy, two weeks, starting June 15.
MEDICINE—Intensive General Course, two weeks, starting May 4.
Electrocardiography and Heart Disease, two weeks, starting May 4.
Allergy, one month and six months, by appointment.
CYSTOSCOPY—Ten-day Practical Course starting every two weeks.
DERMATOLOGY—Intensive Course, two weeks, starting May 11.

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the U. S. Naval Academy (1943) and served as a Navy pilot during the war.

* * *

F. C. Swartz, M.D., Lansing, addressed the Barry County Medical Society at Hastings on "Geriatric Philosophy" on April 21.

* * *

The Michigan State Medical Assistants Society will hold its convention at the Morton House, Grand Rapids, on Wednesday and Thursday, September 23 and 24, 1953. The nurses and secretaries of all MSMS members are cordially invited to attend the MSMAS convention. The tentative program is as follows:

Wednesday, September 23

9-10	Registration
9:30	Executive Board Meeting
10-12	Speakers
12:30	Free luncheon
2:00	Business meeting
6:00	Cocktail hour
7:30	Banquet—speaker

Thursday, September 24

9-10	Registration
10-12	Speakers
12:30	Presidents' Luncheon (Style Show)
2:00	Speakers
3:00	View Exhibits

The Michigan State Medical Assistants Society and the Advisory Committee of the Michigan State Medical Society have determined that the immediate project of the Medical Assistants Society is to gain additional members throughout Michigan. Therefore the MSMS Advisory Committee recommended that all doctors of medicine be urged to speak to their assistants regarding membership and, wherever the number warrants, the forming of a constituent society. Local societies exist in Detroit, Lansing, Grand Rapids, Saginaw, Bay City, Muskegon, Kalamazoo and Allegan.

Active membership is open to any eligible person actively employed in the office of a member of the Michigan State Medical Society, in hospitals accredited by the AMA, and in medical laboratories of the State of Michigan. The organization is declared to be non-profit.

The object of the society is to train its members to be more efficient in their services to the public and to the medical profession.

Further information regarding membership in the Michigan State Medical Assistants Society may be obtained from Miss Katherene Brown, 542 Maccabees Bldg., Detroit 2, Michigan.

* * *

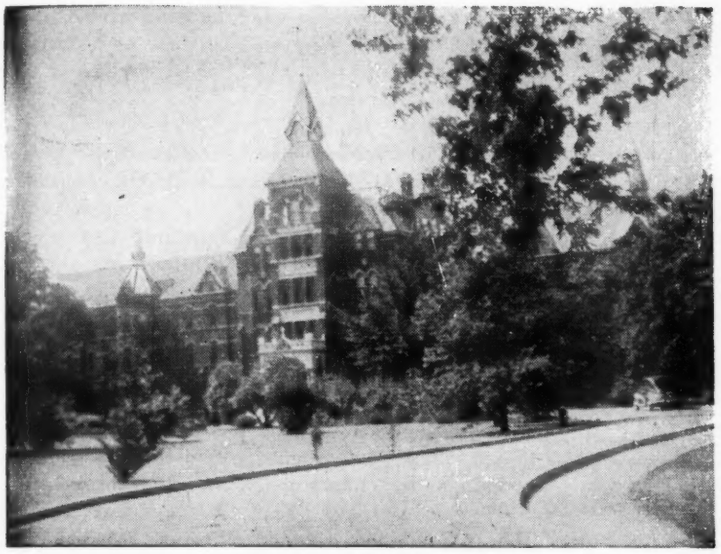
Joseph A. Navarre, J.D., State Insurance Commissioner, addressed the monthly staff conference of Woman's Hospital, Detroit, on March 6. His subject was "Hospital Care and Hospital Costs."

* * *

Fedora Protar, who provided medical care for the residents of Beaver Island beginning in 1892, was hon-

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Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

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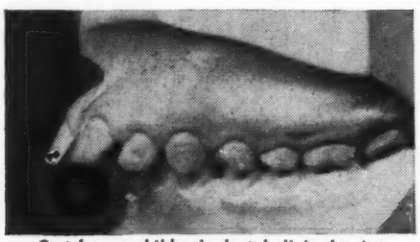
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ored on March 4, the twenty-eighth anniversary of his death. A bronze tablet on the lonely grave of Dr. Protar, who is believed to have been a Russian refugee, reads:

> "To our heaven-sent friend in need, Fedora Protar, who never failed us. In imperishable gratitude and adoration. His people of Beaver Island."

The 1953 pilgrimage of Beaver Island residents to Protar's grave coincided with the good news that Harry Vail, M.D., of Bay City will be their new doctor, succeeding Russell Palmer, M.D., who retired after twenty-eight years of service.

* * *

Year-round Medical Class.—Seniors at the University of Michigan Medical School will begin year-round classes June 23.

The class of 150 will be split into five groups of thirty each, with four groups in attendance and one on vacation. The year will be divided into five nine-week periods separated by a week-long rest period.

Thus, at some time during the year, each senior student will have a holiday of from eleven to thirteen weeks. The only time the school will not be in session will be during the two-week Christmas period.

Dean Albert C. Furstenberg said the change will give seniors a better chance to obtain externships.

* * *

The Combined Armed Forces Medico-Military Symposium for all armed forces is to be held at the U. S. Naval Hospital, Great Lakes, Illinois, May 6, 7 and 8, 1953. For program, write Capt. W. H. Schwartz, M.C., USN., Chairman, Program Committee, at the Naval Hospital.

* * *

Harold C. Mack, M.D., Detroit, has been chosen President-Elect of the Central Association of Obstetricians and Gynecologists which will hold its next meeting in Houston, Texas, on November 5, 6 and 7, 1953.

* * *

The first Beaumont Memorial Lecture of the Michigan State Medical Society will be given on the occasion of the MSMS Annual Session in Grand Rapids, September 23, 24 and 25, 1953. This new lectureship will commemorate the pioneer work done in Michigan by Dr. William Beaumont, who began his physiological experiment on Mackinac Island in 1822.

It is most fitting that the Beaumont Memorial Lecture be created in 1953, as this year marks the 100th anniversary of the death of Dr. Beaumont.

* * *

John R. Rodger, M.D., Bellaire, and **H. B. Zemmer, M.D.**, Lapeer, were official representatives of the Michigan State Medical Society and of the Michigan Health Council, respectively, at the National Health Council annual meeting in New York on March 18 and 19.

* * *

At the American College of Surgeons Inter-American Session in Sao Paulo, Brazil, Michigan was represented by Don F. Cudner, M.D., Elmore F. Lewis, M.D., E. W. McGarvey, M.D., Philip A. Riley, M.D., John Van Schoick, M.D., all of Jackson, Michigan; F. J. Melges, M.D., Battle Creek, and B. F. Glowacki, M.D., Detroit.

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The American Goiter Association will hold its 1953 meeting at the Drake Hotel, Chicago, May 7, 8 and 9. The program will deal with goiter and other diseases of the thyroid gland. For information, write George C. Shivers, M.D., Colorado Springs, Colorado.

* * *

The American Medical Association Annual Session will be held in New York City, June 1-5, 1953. Headquarters will be the Grand Central Palace.

* * *

The International College of Surgeons announces plans for a worldwide Surgeons' Hall of Fame to be established in the world headquarters of the IC of S in Chicago. This Hall of Fame will commemorate the contributions by surgeons to the life and health of human beings. The site of the Hall of Fame will be the recently purchased limestone mansion at 1520 Lake Shore Drive, Chicago, next to the headquarters of the College.

* * *

James Devereaux, 904 Riker Building, Pontiac, is the new Executive Secretary of the Oakland County Medical Society, appointed as of January 1, 1953.

Congratulations, Oakland County members, on this progressive step.

* * *

C. Paul Hodgkinson, M.D., Detroit, was elected Secretary of the American Academy of Obstetrics and Gynecology at its recent annual meeting in Chicago.

Dr. Harvey M. Merker of Parke, Davis & Co., Detroit, recently was elected president of the Detroit Library Commission.

Dr. Merker will be remembered as one of the guest speakers at the Beaumont Memorial Breakfast, sponsored by the Michigan State Medical Society in Detroit, September 25, 1952.

* * *

The Upper Peninsula Medical Society will hold its 1953 meeting in Escanaba on Friday and Saturday, June 19 and 20. Louis P. Groos, M.D., of Escanaba, is president and N. L. Lindquist, M.D., of Escanaba, is secretary of the UP Medical Society.

* * *

Central Association of Obstetricians and Gynecologists.—The Central Association of Obstetricians and Gynecologists announce the election of the following officers: President: W. O. Johnson, M.D., Louisville, Ky.; President-Elect: Harold C. Mack, M.D., Detroit, Mich.; Vice President: Arthur B. Hunt, M.D., Rochester, Minn.; Secretary-Treasurer: Harold L. Gainey, M.D., Kansas City, Mo.; Assistant Secretary: Woodard D. Beacham, M.D., New Orleans, La.

These officers will serve until the end of the Annual Meeting which will be held at the Shamrock Hotel, Houston, Texas, on November 5-7, 1953.

The business office of the Central Association of Obstetricians and Gynecologists is located in Suite 602,

Say you saw it in the Journal of the Michigan State Medical Society

116 So. Michigan Avenue, Chicago 3, Illinois. The office of Dr. Harold D. Gainey, Secretary-Treasurer, is located at 4635 Wyandotte Street, Kansas City, Missouri.

* * *

Aid To Dependent Children.—The Michigan Department of Social Welfare which adminsters the Old Age Assistance, aid to Dependent Children, and rehabilitation, requests that Doctors of Medicine who have to make out any of their reports be especially careful in filling out the blanks so the Medical Advisor may have a picture sufficient to determine the exact condition and needs. This holds especially for dependent children when he must determine if the child is dependent. Is the parent able to work? Give precise diagram of the employability. Much depends on this co-operation, as there are proper sources of aid if the case is not one of dependence due to no parent or one not employable.

* * *

1953 Industrial Health Conference.—The 1953 Industrial Health Conference was held in Los Angeles, April 18 to 25, 1953.

There was a joint meeting of the Industrial Medical Association, American Conference of Governmental Industrial Hygienists, American Industrial Hygiene Association, American Association of Industrial Dentists, and American Association of Industrial Nurses.

These items of interest to Michigan appeared on the program.

"Industrial Hygiene for Small Industry and the Solitary Worker"—W. G. FREDRICK, Sc.D., Bureau of Industrial Hygiene, Detroit Department of Health, Detroit, Michigan

Forum Discussion—"The Function of Industrial Dentistry." Discussion Leader: GRANT U. MACKENZIE, Dental Director, Ford Motor Company, Dearborn, Michigan

Session Arranger: BENJAMIN LINSKY, Chief, Smoke Abatement Bureau, Department of Buildings and Safety Engineering, Detroit, Michigan

"The Detroit Air Pollution Control Program"—BENJAMIN LINSKY, Chief, Smoke Abatement Bureau, Department of Buildings and Safety Engineering, Detroit, Mich. (film with live commentary)

"The Toxicology of Monomethyl Ethers of Mono, Di and Tripropylene Glycols (Dowanol 33B, 50B, 62B respectively)"—V. K. ROWE, H. C. SPENCER, Ph.D., D. D. MCCOLLISTER, F. OYER and R. L. HOLLINGSWORTH, Dow Chemical Company, Midland, Mich.

Session Arranger: WALTER H. KONN, Industrial Hygiene Department, General Motors Research Laboratories, Detroit, Mich.; Co-chairmen to be announced.

"Community X-Ray Hazards"—W. G. FREDRICK, Sc.D., Bureau of Industrial Hygiene, Detroit Department of Health, Detroit, Mich.

"Case Histories of Collector Efficiency Measurement Studies at Ford Motor Company"—J. C. RADCLIFFE and W. F. DELHEY, Industrial Health Unit, Ford Motor Company, Dearborn, Michigan.

* * *

American Board of Obstetrics and Gynecology.—The Directors of the American Board of Obstetrics and Gynecology wish to express their thanks to the following gentlemen who responded so willingly to our request for help in proctoring the recent written examinations, February 6, 1953.





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Among the long list of names submitted are: Henry W. Clapp, M.D., Muskegon; George Kamperman, M.D., Detroit; Reynold L. Haas, M.D., Ann Arbor; F. W. Tamblyn, M.D., Lansing; Athol B. Thompson, M.D., Grand Rapids, and Clarence E. Toshach, M.D., Saginaw.

The next scheduled examinations, Part II (oral and pathological) for all candidates will be held at The Edgewater Beach Hotel, Chicago, Illinois, by the entire Board, May 17 through 24, 1953. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examinations.

Applications for Certification for the 1954 (Part I) examinations are now being accepted, and candidates are urged to make such application some time in August or September. This would be of great help in expediting processing of these applications.

Requests for Applications for Appraisal of Incomplete Training Applications for Certification, current Board Bulletins, and Preceptorship or Supplemental Training Forms should be made to: Robert L. Faulkner, M.D., Secretary, American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

* * *

Edmond L. Cooper, M.D., of Detroit, has been re-elected President of the Detroit Society for the Prevention of Blindness. Other physicians serving on the Board of Directors of the Society are Cecil W. Lepard, M.D., A. D. Ruedemann, M.D., Nelson Taylor, M.D., and Joseph Molner, M.D.

Pediatric Problem in Michigan.—

Motion: "In the interest of improving child health, the Child Welfare Committee of the Michigan State Medical Society recommends that the MSMS supports such activities as would improve and insure good intern training programs particularly in child care and further, that the MSMS recommend that those hospitals approved for internships comply with the regulations set forth by The Council on Hospitals and Education of the American Medical Association Governing Intern Training. Carried."

This action of the Child Welfare Committee was approved by the Executive Committee of the Council. In the whole State of Michigan there is one doctor to each 915 residents, but outside of Wayne County the ratio is one to 1,490 persons. There are thirty-three Michigan hospitals approved for intern training, with 513 internships available, but only 300 of these were filled in 1952. Sixty per cent of interns stay in or near the place of training. The February 27, 1953, JAMA announced the new ruling that if after two years a hospital has had no interns the approval may be revoked. Seventy per cent of the maternity and children's illnesses are cared for by general practitioners while approximately 45 per cent of physicians have had no pediatric training after their internship. It is hoped that the MSMS should guarantee a complete training by actively promoting the provision of training in the four major practices: Obstetrics, Pediatrics, Medicine and Surgery. The expression was that interns are not at hospitals for service, but for educational training, and that all doctors practicing and all hospitals and patients should be a part of this program.

Say you saw it in the Journal of the Michigan State Medical Society

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

VIRAL AND RICKETTSIAL DISEASES. 2nd Edition. Edited by Thomas M. Rivers, M.D., Director of Hospital, Rockefeller Institute for Medical Research. 719 pages. Illus. Philadelphia: J. B. Lippincott Co., 1952. Price $7.50.

As knowledge grows in the field of viral and rickettsial diseases, the need is great for a source of information which is reliable and one that is frequently brought to date. Such a source can be found in the new text published by the J. B. Lippincott Company and edited by Thomas M. Rivers, M.D.

This is the second edition and is titled "Viral and Rickettsial Infections of Man." The text was made possible by direct subsidy from the National Foundation for Infantile Paralysis, Incorporated, and lists as contributors outstanding research workers as it would be impossible for any one man to write with authority about all the diseases and their casual agents reported.

The text is not a research manual but is intended for medical students and physicians. It does report methods and history which are intended as collateral background information in this field. Its value to physicians lies in the demonstration of laboratory difficulties encountered and the proper methods and sampling procedures when diagnosis is necessary.

The organization of each report is interesting and practical. It consists of an introduction, history, clinical picture, pathologic picture, experimental infection, etiology, diagnosis, treatment, epidemiology and control measures. The last two are included to give a complete picture of viral and rickettsial infections for medical students and physicians.

Certain sections of the first edition have been deleted in the new text since their causative agents have been found to be other than viruses and rickettsiae.

Discussion of the newly discovered Coxsackie viruses are included and there are new chapters on viral hemaglutination and interference between animal viruses.

Valuable information for the practice of medicine is scattered throughout the book and at times either student or physician may have difficulty in finding it in a usable form. In an effort to overcome some of this difficulty, an integration of knowledge about viral and rickettsial infections of man has been attempted in a special chapter on diagnosis.

OPERATING ROOM TECHNIC, St. Mary's Hospital, Rochester, Minnesota. Fourth Edition. Illustrated. Philadelphia: W. B. Saunders Co., 1952.

Years ago a cyclone and an urgent request by the Doctors Mayo to the Sisters of Saint Francis for help in caring for the injured, brought about the construction of the St. Mary's Hospital at Rochester, Minnesota. St. Mary's is a unique institution. Once a nun enters St. Mary's, she devotes a lifetime to nursing within the walls of the hospital. For example, the nun who edited

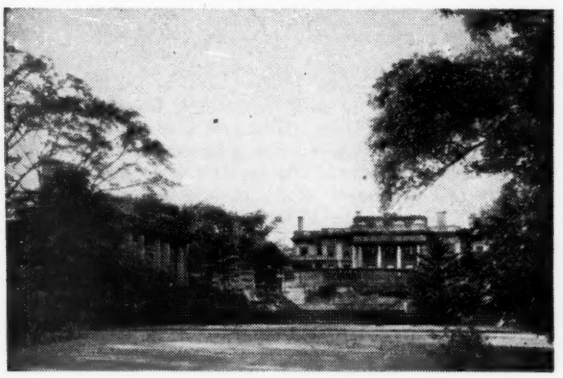


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the third revision in 1937 and who was affectionately known as Sister "Bill," labored seven days a week and many a night for forty-odd years in the operating rooms.

With this background then, it will become quite clear to the reader that the technics presented are the ones in daily use by Mayo Clinic surgeons. The text itself is clear and concise. The present volume has been completely rewritten. New sections on Urology and Peroral Endoscopy have been added. The text contains many excellent illustrations. Little gems of surgical wisdom will be found from time to time in the paragraphs describing procedure. This book is recommended as a text for teaching operating room nursing personnel and for interns and residents. The general surgeon could well find a spot for it in his own library.

J.W.H.

GIFFORD'S TEXTBOOK OF OPHTHALMOLOGY. By Francis Heed Adler, M.D., Professor of Ophthalmology, University of Pennsylvania Medical School; Consulting Surgeon, Wills Eye Hospital, Philadelphia. Fifth Edition. Illustrated with 281 colored figures and 26 color plates. Philadelphia: W. B. Saunders Co., 1952.

This book will meet the needs of the undergraduate student of ophthalmology and at the same time, gives the general practitioner a ready reference for his needs about opthalmological problems. The whole book is carefully written and the author gives practical information to the general practitioner about eye problems that may arise in his daily practice. That section that deals with hypertensive diseases and diabetes, together with diseases of the optic nerve, is worth the price of the book.

W.S.J.

A MANUAL OF CLINICAL ALLERGY. Illustrated. By John M. Sheldon, M.D., Professor of Internal Medicine, University of Michigan Medical School; Assistant to the Chairman of the Department of Postgraduate Medicine; Physician in Charge of University of Michigan Allergy Clinics; Director of The Montgomery Allergy Research Laboratory; Robert G. Lovell, M.D., Instructor in Internal Medicine, University of Michigan Medical School, and Kenneth P. Mathews, M.D., Assistant Professor of Internal Medicine, University of Michigan Medical School. Philadelphia: W. B. Saunders Co., 1953. Price $8.50.

We have received this book by our own Dr. Sheldon of Ann Arbor with a great deal of interest. We first turned to comments about house dust. Dr. Sheldon is modest. He makes no mention of the history of the house dust problem. The reviewer was his first patient in the determination of the causative factor of house dust in allergy. We took the contents of a carpet sweeper to Ann Arbor. Dr. Sheldon had it processed, a vaccine made and gave the reviewer great relief.

The matter of food allergies was also of interest. The reviewer was sensitive to almost all foods. What to avoid? Almost all of them. However, we worked out an elimination diet which provided an ultimately satisfactory diet. Dr. Sheldon might claim this pioneer-

ing research. (We have asked him to write it for the use of THE JOURNAL, but without success.) We are now giving him credit for two pioneering factors in allergy. We are happy to have this very up-to-date and useful book.

W.H.

ORAL ANATOMY. By Harry Sicher, M.D., D.Sc., Professor of Anatomy and Histology, Loyola University School of Dentistry, Chicago College of Dental Surgery; Guest Lecturer, Northwestern University, Dental School, Chicago. With 310 Text Illustrations including 24 in color. Second Edition. St. Louis: The C. V. Mosby Co., 1952.

This book is written primarily for students of dentistry and oral surgery to supplement their study of dental and human anatomy. Readers will find that it contains concise basic anatomy of the head and neck with elaboration on the portions specifically essential for dentists and oral surgeons.

The text is divided into two parts. The first portion deals with descriptive anatomy of the bones of the skull, and soft tissue of the head and neck. The chapter on the temporomandibular articulation is particularly well covered. The second portion deals with regional and applied anatomy of the same structures with special emphasis on the anatomy of alveolar processes and the anatomy of local anesthesia. The chapters entitled The Propagation of Dental Infections and The Temporomandibular Articulation should be of particular interest to dental surgeons.

Dentists, oral surgeons, and otolaryngologists will find this book to be a valuable adjunct in their studies.

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ARTIFICIAL INSEMINATION

(Continued from Page 423)

wife, the child and the donor are all in an unsatisfactory position with respect to the law. Statutes will have to be enacted, either regulating the practice and outlining the rights and liabilities of the parties concerned, or making the practice a criminal offense. As a practical matter the latter is not to be anticipated, for the reason that the practice has become too widespread, and the judicial comment in this country has been too favorable.

There has been no attempt here to consider the effect of conflict of laws on the status of a child conceived by AID. That problem is one that will come with the statutory determination of the status of the child, and it suggests some interesting possibilities. My own conclusion is that adoption is the best way to bring wanted children into the childless home.

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DON'T ROCK THE BOAT

(Continued from Page 440)

few years some doctors have been convicted of income tax evasion. Some months ago we commented in these columns that income tax inspectors were going through medical men's income tax reports with special attentiveness. We repeat the warning.

The medical profession of Michigan has reason to be proud of its accomplishments in many fields. There are no more devoted doctors of medicine in the whole country, and none able to give better health and contentment to our public. We have favorable relations with ourselves and our people. It behooves us to take extra precautions to preserve the good repute and good returns which are ours. One small mishap or misstep can undo the good esteem which cost hundreds of thousands of dollars to establish, and which it might not be possible to re-establish.

We congratulate our members on their good will. We bespeak a continuance of it. But **Don't Rock The Boat.**

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WANTED: Medical doctor, 35 or under, to do general practice in Arenac County, Michigan, on independent basis or assistant, as may be agreed. Ten thousand population, good schools, thirty-bed, well-equipped and staffed private hospital in the county. Applicants should contact Hugh O. Staley, M.D., Omer, Michigan.

FOR SALE: Building in Cambridge, Wisconsin, built to be physician's offices and his home. This city is anxiously seeking a competent doctor. This small clinic type building is about three years old and very modern, the price is less than the construction cost and will be sold to qualified man on easy terms. This city is located 22 miles east of Madison and 58 miles west of Milwaukee. For further details, write or call A. M. Wheeler, 536 W. Wisconsin Avenue, Milwaukee, Wisconsin.

FOR SALE OR LEASE: General Practice in small village near industrial city of Jackson. Good roads and ten minutes from two well-equipped hospitals. Office in home without added over-head. Gross between $12,000.00 to $15,000.00 a year. Leave on or before April 1, 1953. Terms reasonable. Reply to W. L. Foust, M.D., Grass Lake, Michigan.

INDEPENDENT MEDICAL EXPERTS TO TESTIFY IN INJURY CASES

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paid $50 for each examination. The plan budgeted $6,000 for a paid director to supervise the program and to prepare a report on its results. Professor Delmar Karlen of the Institute of Judicial Administration at New York University Law School has been obtained to direct the project.

The *New York Heard Tribune* calls it a "development to be cheered."